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Improved Program Delivery

Health and Sports

A Study Team Report
to the Task Force on Program Review

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HEALTH AND SPORTS PROGRAM

A Study Team Report
to the Task Force
on Program Review

November 20, 1985

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FOREWORD

The Task Force on Program Review was created in September 1984 with two major objectives - better service to the public and improved management of government programs. Recognizing the desirability of involving the private sector in the work of program review, assistance from national labour, business and professional organizations was sought. The response was immediate and generous. Each of these national organizations selected one of their members to serve in an advisory capacity. These public spirited citizens served without remuneration. Thus was formed the Private Sector Advisory Committee which has been responsible for reviewing and examining all of the work of program review.

The specific program reviews have been carried out by mixed study teams composed of a balance of private sector and public sector specialists, including representatives from provincial and municipal governments. Each study team was responsible for the review of a "family" of programs and it is the reports of these study teams that are published in this series. These study team reports represent consensus, including that of the Private Sector Advisory Committee, but not necessarily unanimity among study team members, or members of the Private Sector Advisory Committee, in all respects.

The review is unique in Canadian history. Never before has there been such broad representation from outside government in such a wide-ranging examination of government programs. The release of the work of the mixed study teams is a public acknowledgement of their extraordinarily valuable contribution to this difficult task.

Study teams reviewed existing evaluations and other available analyses and consulted with many hundreds of people and organizations. The teams split into smaller groups and consulted with interested persons in the private sector. There were also discussions with program recipients, provincial and municipal governments at all levels, from officials to cabinet ministers. Twenty provincial officials including three deputy ministers were members of various study teams.

The observations and options presented in these reports were made by the study teams. Some are subjective. That was necessary and appropriate considering that the review phase of the process was designed to be completed in a little more than a year. Each study team was given three months to carry out its work and to report. The urgent need for better and more responsive government required a fresh analysis of broad scope within a reasonable time frame.

There were several distinct stages in the review process. Terms of reference were drawn up for each study team. Study team leaders and members were appointed with assistance from the Private Sector Advisory Committee and the two Task Force Advisors: Mr. Darcy McKeough and Dr. Peter Meyboom. Mr. McKeough, a business leader and former Ontario cabinet minister, provided private sector liaison while Dr. Meyboom, a senior Treasury Board official, was responsible for liaison with the public sector. The private sector members of the study teams served without remuneration save for a nominal per diem where labour representatives were involved.

After completing their work, the study teams discussed their reports with the Private Sector Advisory Committee. Subsequently, their findings were submitted to the Task Force led by the Deputy Prime Minister, the Honourable Erik Nielsen. The other members are the Honourable Michael Wilson, Minister of Finance, the Honourable John Crosbie, Minister of Justice, and the President of the Treasury Board, the Honourable Robert de Cotret.

The study team reports represent the first orderly step toward cabinet discussion. These reports outline options as seen by the respective study teams and present them in the form of recommendations to the Task Force for consideration. The reports of the study teams do not represent government policy nor are they decisions of the government. The reports provide the basis for discussion of the wide array of programs which exist throughout government. They provide government with a valuable tool in the decision-making process.

Taken together, these volumes illustrate the magnitude and character of the current array of government programs and present options either to change the nature of these programs or to improve their management. Some decisions were announced with the May budget speech, and some subsequently. As the Minister of Finance noted in the May budget speech, the time horizon for implementation of some measures is the end of the decade. Cabinet will judge the pace and extent of such change.

These study team reports are being released in the hope that they will help Canadians understand better the complexity of the issues involved and some of the optional solutions. They are also released with sincere acknowledgement to all of those who have given so generously of their time and talent to make this review possible.

TERMS OF REFERENCE

There are 28 programs directed in whole or in part to health and sports as shown in the attached list. These programs are estimated to cost $12.3 billion in operating expenditures and tax transfers in 1985/86. They involve 5,850 person-years in seven departments and agencies.

The major portion of these expenditures is made under the Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, 1977. Under Part VI of the Act, the federal government contributes to the financing of insured health services, extended health care services and post-secondary education through cash payments and tax transfers. The cash payment portion relating to health is estimated at $6,685 million broken down into Hospital Insurance and Medical Care ($5,609 million) and extended health care services ($1,076 million); tax transfers relating to health amount to an estimated $4,558 million. Since these programs are operated by provincial and territorial governments, they cannot be treated in the same manner as programs operated exclusively by the federal government.

Besides the above programs, there are three tax expenditure programs accounting for about $205 million broken down as sales tax exemptions ($145 million) and personal income tax exemptions ($60 million).

Finally, there are 24 health and sports programs administered directly by the federal government. They account for 5,826 person-years and expenditures of $429 million in operating costs, $74 million in capital costs and $318 million in transfer payments for a total of $821 million. Thirteen of these have interlinkages with other study teams reporting to the Ministerial Task Force.

Health care costs per capita are significantly higher for older people than for the younger population. The increased life expectancy of individual Canadians coupled with a decrease in natality, will severely strain the capacity of government and taxpayers to fund health care services in years to come, unless ways are found to slow down the increase in costs while ensuring that the quality of care is being maintained at a reasonable level. This can be achieved only through imaginative and cooperative efforts by governments and the private sector alike. The study team will examine these various cost pressures.

TERMS OF REFERENCE

The Ministerial Task force on Program Review seeks the advice and recommendations of the study team regarding the health and sports programs of the federal government with particular emphasis on the cost pressures facing all governments in the delivery of health care services and the possibility of alternative delivery systems that would meet the criteria of increased cost effectiveness while maintaining quality health care.

Considering the nature of programs covered by this review, these terms of reference distinguish between those programs dealing with federal support of health programs operated by the provincial and territorial governments, and those covering health and sports programs operated exclusively by the federal government.

With respect to programs operated by the provinces and territories, the study team is asked:

to provide the Ministerial Task Force with an understanding of the health care delivery system in Canada, its financing, constraints and cost pressures;

to acquaint ministers with the major perceptions of the health care system within the provincial/territorial health communities. These are to be drawn mainly from key individuals in provincial ministries of health and finance and from health related associations and agencies. In this connection, particular attention will be paid to those perceptions which appear to be most prevalent in all or most of the provinces and territories;

to determine whether any suitable alternative mechanisms or technologies are available or can be identified that could meet the criteria of increased cost effectiveness and maintenance of quality health care.

to recommend to ministers, in the light of findings, any additional steps which may be required.

With respect to health and sports programs administered exclusively by the federal government, the study team is asked to identify:

areas of duplication between the federal and provincial governments with respect to health and sports, and with respect to the federal jurisdiction;

programs that might be eliminated;

programs that could be reduced in scope;

groups of programs that could be consolidated;

programs whose basic objective is sound but whose form should be changed;

a summary overview of the legislation that would be required to implement any of these program changes;

the resource implications of any recommended program changes, including changes in resource levels and the number and location of either increases or decreases in staff.

As part of the review of programs operated exclusively by the federal government, the study team is asked to provide information regarding:

Beneficiaries

The principal beneficiaries of federal health and sports programs;

the geographical distribution of expenditures in relation to needs;

beneficiaries of federal programs who are also beneficiaries of provincial programs;

beneficiaries of more than one federal program;

overall allocation of research effort across sectors and groups of beneficiaries.

Efficiency and Overlap

Programs which are particularly troublesome to beneficiaries in terms of red tape, paper work and delays;

Illustrative cases where individuals or groups are beneficiaries of several benefits or services, including tax expenditures and programs of provincial governments and the programs are:

- complementary
- seem to work at cross-purposes
- involve substantial duplication or overlap;

cases where several overlapping programs might be consolidated into one;

the utility, quality and timeliness of delivery of benefits and services experienced by the clientele;

the degree to which health and sports programs stem from past commitments;

the coordination of federal programs with other providers of health and sport benefits;

purposes and benefits of various health research programs;

approaches in other countries which may be relevant to the study;

number and location of offices across the country.

Gaps and Omissions

Direct spending or tax expenditure programs which should be taken into account in this review of health and sports programs but are not in the initial list of programs can be assigned for review following consultation with the Ministerial Task Force.

LINKAGES WITH OTHER STUDIES

The team will identify for the Ministerial Task Force in its detailed work plan any health and sports related issues or programs that have been reviewed by previous Task Force teams, or are in the process of being reviewed through other means, where it is the judgment of the team that important health and sports related questions were not addressed in the initial review and that a "second opinion" would be useful for ministers.

ACCESS TO INFORMATION AND DATA SOURCES

The study team will have access to all evaluations, reviews and reports on health and sports programs prepared over the past several years, as well as any other existing information and data from central agencies and services and program organizations. A review of this information will be conducted by the study team and if additional data are required, program departments will be requested by the study team, on behalf of the Ministerial Task Force, to collect such data.

COMMUNICATION WITH DEPARTMENTS

These terms of reference have been developed in consultation with the Deputy Minister of National Health and Welfare, and the Secretary to the Cabinet for Federal/Provincial Relations.

Ministers of those departments directly affected by this review will be advised which programs under their jurisdiction will be reviewed.

In addition, the study team will initiate appropriate liaison and consultation with deputy ministers and senior managers whose programs are affected by the study.

COMPOSITION OF THE STUDY TEAM

The study team shall be led by a private sector representative or by a senior government official at the EX 4-5 level, who will be appointed in consultation with the departments most closely affected by this program assessment. The Team Director will report to both the Public Sector Advisor and the Private Sector Liaison Advisor Serving the Chairman of the Task Force.

In addition, the team will consist of a deputy team leader and six other members with a balanced senior management representation from the federal and provincial governments and the private sector. One or two research assistants may be added to the team as appropriate.

WORK PLAN

Following approval of its Terms of Reference and after a review of available evaluations and assessments of programs identified for review, the study team will submit for consideration by the Ministerial Task Force a detailed work plan showing the revised program listing, the organization by sub-teams, the activities to be undertaken and the schedule for accomplishing the work required.

REPORT SCHEDULE

The study team is requested to submit its initial findings to the Ministerial Task Force on September 30, 1985 and a final report on October 31, 1985. In addition, the Task Force will receive brief progress reports on the work of this and other study teams at all regular meetings.

LIST OF THE PROGRAMS OF HEALTH AND SPORTS

DEPT.	PN	TITLE
EAC	107	INTERNATIONAL SPORTS RELATIONS
FASC	1	FITNESS AND AMATEUR SPORTS - SPORT CANADA
FASC	2	FITNESS AND AMATEUR SPORT CANADA - FITNESS
FIN-TEP	7	MEDICAL EXPENSE DEDUCTION
FIN-TES	6	HOSPITAL PURCHASES
FIN-TES	7	HEALTH APPLIANCES
HWC	17	CIVIL AVIATION MEDICINE
HWC	18	QUARANTINE AND REGULATORY
HWC	19	EMERGENCY SERVICES
HWC	20	INDIAN HEALTH SERVICES
HWC	21	NORTHERN HEALTH SERVICES
HWC	22	IMMIGRATION MEDICAL SERVICES
HWC	23	PROSTHETIC SERVICES
HWC	24	PUBLIC SERVICE HEALTH
HWC	100	FOOD SAFETY, QUALITY AND NUTRITION
HWC	101	DRUG SAFETY, QUALITY AND EFFICACY
HWC	102	ENVIRONMENTAL QUALITY AND HAZARD
HWC	103	NATIONAL HEALTH SURVEILLANCE
HWC	104	HEALTH SERVICES AND RESOURCES
HWC	105	HEALTH PROMOTION
HWC	106	HEALTH INSURANCE
INAC	231	CONTRIBUTION TO THE TERRITORIAL GOVERNMENT FOR HOSPITAL/MEDICAL
MRC	1	MEDICAL RESEARCH COUNCIL OF CANADA
OWG	7	GOVERNMENT OF CANADA OFFICE 1988 XV OLYMIPIC WINT
SC	113	HEALTH STATUS
SC	117	HEALTH CARE
TC	30	SPORT
FC	192	EPF-HEALTH (TAX POINT TRANSFER)

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OVERVIEW

Introduction

In the field of health services, there is a constitutional division of responsibilities and powers between federal and provincial governments in Canada. The federal government has direct responsibility for personal health services for specified groups of people only (i.e. the Armed Forces, R.C.M.P., inmates of federal prisons and the federal civil service for occupational health services). The federal government provides personal health services for Indian and Inuit peoples throughout Canada as well as providing a range of public health, dental health and institutional services throughout the Yukon and Northwest Territories under contract with the territorial governments.

On matters of a national and international nature, the federal government provides a range of consultative, statistical, reference laboratory, regulatory (i.e. food products, drugs, medical devices and environmental contaminants), quarantine, immigration and research support services. The federal government is also involved in significant activities with respect to health promotion.

The major impact of the federal government on health care for Canada's general population has come from its use of tax revenue to stimulate and support provincial health insurance programs and other health services.

Since 1977, under the Established Programs Financing Act, a combination of tax point transfers and block grants have been provided under broad conditions to the provinces for their use. This funding has been escalated annually based on increases in the Gross National Product.

The Canada Health Act (1984), reaffirmed the general principles of our national health care system - universality, comprehensiveness, accessibility, portability and public administration. This legislation incorporates penalties in the form of withholding federal funds to a province on a discretionary basis for contravention of these five principles as well as non-discretionary penalties should that province permit "extra-billing" by physicians or "user-charges" in other components of the system.

Public funding of health care now represents approximately 75% of total spending on health services (exceptions include dental services, most prescriptions, co-insurance in long-term care facilities, eye glasses, etc.). Over 90% of hospital care and physician's care costs are now paid through provincially administered plans. The total value of health services provided in Canada from public and private sources in 1984 was $36 billion.

The provinces play a major role in providing capital funding for hospitals and other health facilities, and ensure the provision of public health services.

Governments are taking an increasing role in the health care system. However, in the delivery of Canada's health services the non-governmental sector continues to play a dominant role. The vast majority of physicians and dentists are private practitioners. These professions, as well as nursing and pharmacy, are fully or largely self-governing and self-regulating under provincial legislation.

Most other health care personnel, including nurses, are employed on a salary basis by an institution or program within the health care system. Most hospitals in Canada are owned by not-for-profit corporations, religious bodies or local government.

MAJOR FINDINGS AND OPTIONS

Established Programs Financing (EPF)

Current arrangements under EPF tie federal funding to economic growth and capacity, thus providing an element of predictability based on economic grounds, not on health cost increases. Block funding was intended to provide the provinces with funding not related to spending levels in health.

In this context, the unilateral division of EPF into separate health and post-secondary education components was inconsistent with the concept of total "block funding".

In the field of health, it is the view of the study team that provinces have not yet been able to limit cost escalations to solid economic targets. Given the public popularity of "no-cost" health care, provincial administrations have generally not implemented significant and long-lasting cost control measures.

However, based on this review, the study team concludes that there are no compelling program reasons to reduce transfer payments. Thus, the announced intent of the federal government to reduce the amount of transfer payments by $6 billion over the next five years is seen strictly as a necessary fiscal measure. The team fears, however, that this action by the federal government could substantially reduce its role in Canada's health care system. The percentage of federal government contributions to provincial health programs is currently at approximately 40%. The team found no evidence that would indicate that our health system is significantly "overfunded" or "underfunded" - rather a balance overall appears to have been achieved at the present time. However, cost pressures are building up, as our "Health Issues" paper shows.

The team has identified a number of options to improve and stabilize the federal/provincial relationships, with the intent to reduce friction between the two senior levels of government on matters of finance and jurisdiction; and to permit for positive collaboration on the issues facing our health care system.

Canada Health Act

This legislation was specifically supported by all 3 federal political parties and many community interest groups when it was passed in 1984. It has restated the federal government's responsibility for ensuring the five principles of our health system:

- universality of benefits;
- comprehensiveness of services;
- accessibility to services;
- portability throughout Canada; and
- public administration.

The Act provides for discretionary penalties for contravention of these five principles by provincial administrations.

This restatement of principles was a positive step. However, the highly specific and non-discretionary financial penalties served to reintroduce inflexibility in a system which - the team feels - is crying out for experimentation. As well, the Act was redundant in "allowing" provinces to deal with health care professionals in ways which were already available under provincial jurisdiction.

The Act restricts the flexibility of provinces in responding to pressures within their health systems and, as such, adds irritants to the federal/provincial relationship.

No province can reduce the fabric of their health system without paying a large price politically. Neither the "system" itself, nor the public will allow provincial governments to threaten "their" health care system. The future requires statesmanship to ensure that federal and provincial governments begin to work together in a spirit of achieving common goals in the field of health care delivery. Monitoring of the Canada Health Act should be kept as simple as possible.

We believe that in time, the Act needs to be amended or replaced to permit the federal government to continue to monitor adherence to the five principles of Canada's national health system while removing the provisions which are irritating and inflexible - and which do not of themselves serve to improve or safeguard our health system.

In the area of programs which are provided directly by Health and Welfare Canada, we have made a number of specific suggestions, the essence of which can be summarized as:

Health Protection

The intent of the options presented is to institute a fee for pre-market evaluations of new drugs and new medical devices done by the Drug and Environmental Health Directorates.

Civil Aviation Medicine and Immigration Medical Services

These programs serve a very selective clientele throughout Canada and we have suggested that both programs are more properly located in other departments of the federal government. As well, we see the need for a significant change in the manner in which civil aviation medicine conducts its activities - coupled with full cost-recovery of its resources.

Indian Health, Northern Health and Prosthetic Services

Our view of these programs is that the federal government should disassociate itself with the direct provisions of these services. Prosthetic services should be moved to provincial jurisdiction. Northern Health Services should be divested to the territorial governments and Indian Health Services to provincial governments or, alternatively to community boards. In all these areas, appropriate levels of compensation to those governments involved would be subject to detailed negotiations. Obviously, agreement to this course of action would need to be negotiated with appropriate organizations representing native peoples.

In the case of Indian Health Services and Northern Services, we believe that to effect the transfer over a reasonable time period (1991 and 1987 respectively) a select group of negotiators on behalf of Health and Welfare Canada should be specifically charged with the divestment activities.

Medical Research Council and National Health Research and Development Program

We are satisfied that these two programs are effective and are utilizing the resources available to them in a manner which is nationally beneficial. The team feels that they should not be combined, as each plays a very specific and vital role within the research communities of this country. Their funding levels are reasonable and should not be dramatically changed if "essential quality of research activity" is to be maintained.

Health Statistics and Data (Health Care (SC), Health Status (SC) and Information Systems (HWC))

Health Status activities are seen to be beneficial and useful to both federal and provincial governments and many non-governmental users. Health Care and Information Systems are not as clearly useful as they mainly support interchange of information between provincial governments. The team is concerned that this information is not effectively used once it has been produced.

We are, therefore, recommending to the Task Force that the government consider discontinuing these two programs as of January 1, 1987 subject to an immediate review of the data collected and published. This review should be conducted under the authority of the federal/provincial Deputy Ministers of Health Conference. Resource levels in these programs need to be determined subsequent to that critical appraisal.

Health Services

In large measure, this program supports a huge network of federal/provincial advisory committees, sub-committees and working groups - acting as consultant and as secretary for these activities. As with the health data group, we are recommending to the Task Force that the government consider introducing a moratorium on these committee activities pending a critical review of their continued need. This review should be undertaken by the federal/provincial Deputy Ministers of Health Conference - with resource levels to be determined subsequent to this review.

Emergency Services

A large component of this program is the stockpiling of approximately $50 million of hospital and medical supplies across Canada. No evidence exists that these supplies are frequently used or needed as the provincial health systems have matured and developed their own capacity for handling emergency situations.

We are recommending to the Task Force that the government consider restricting stockpiles to three locations across Canada to be maintained by the Department of National Defence for national emergencies. The balance of current supplies should be given to provincial authorities or to third world countries. Training activities in this program should be on a cost-recovery basis.

Health Promotion and Fitness

We have highlighted in several areas of this report the increased visibility which should be given to promoting healthy lifestyles among Canadians. The pay-offs are long-term and often difficult to quantify, but in our opinion, definitely worthy of continued support by the federal government and provincial governments.

We have suggested a vehicle by which Health Promotion and Fitness Canada would be brought functionally into an "arm's-length" organizational relationship to Health and

Welfare Canada. It is our opinion that, with proper organization and marketing, this new "creature" would be able to attract private sector funds to supplement federal resources in the field of promotion.

Sport

We recommend to the Task Force that the government consider phasing down the program over a 10-15 year period to give the high performance athlete development system some time to seek and establish sufficient viability, both organizationally and financially, to operate relatively independent of government.

Public Service Health

We are concerned with the rapid growth in federal resources being expended in this program area ($9.3 million in 1982/83 to $20.3 million proposed for 1986/87). Specific reasons for these cost increases were not available from program administrators. We recommend to the Task Force that the government consider launching a comprehensive review of this program by external consultants to examine the objectives, resource levels required, "contracting out" options and administrative location within the federal government. Resource levels should not be increased from 1985/86 levels pending this review.

Branch Administration and Departmental Administration

Our terms of reference did not request us to examine these programs. However, we note that in 1986/87 they represent 1,356 person-years and $81.6 million. We believe that these activities should be critically examined with a view to reducing expenditure levels by a minimum of 10%. Organizationally, there does not appear to be a singular focus for "health" in Health and Welfare Canada.

Conclusion

Canada's health care system is acknowledged to be one of the outstanding social programs, in its comprehensive breadth of application, in the world. It is also among the most expensive and most complex systems of governmental, organizational (professional and institutional) and individual inter-relationships which are administered by Canadian governments. Its development has been highlighted by controversy.

We would hope that the options presented by the study team for consideration by the government will, if implemented, serve to lessen over time some areas of that controversy - particularly those that focus on the relationships between federal and provincial governments. As a result, we would hope that the two senior levels of government will begin to work effectively with each other to resolve issues impacting on the ability of this country to offer its citizens quality of health services at affordable costs.

We have also made certain specific suggestions which we believe would serve to reduce costs presently incurred by the federal government in providing services through Health and Welfare Canada.

ISSUES IN THE HEALTH CARE SYSTEM

SECTION 1
Executive Summary

This paper summarizes issues that are currently facing those involved in managing the health care system and that have been identified in recent reports and studies and in consultations with the provinces, national organizations and key individuals. The report also describes some key indicators of the health care system in Canada and the health status of Canadians.

An issue that concerns both the provinces and the federal government is the control of the rate of increase of health care costs. In addressing this issue, this paper looks at the components/contributors to health care cost increases - the increase in the number of elderly people, high technology in health care services, health manpower and usage pressures. A fifth issue, privatization, is also discussed. A brief summary of these issues follows. Section 2 discusses the issues in greater detail, while Section 3 looks at health care indicators under the categories of demographics, health status of Canadians, use of health care services, resources in the system, priority target groups and health care costs.

The Elderly

Canada can expect a substantial increase in the number of elderly people (65 years +) in the coming years. The proportion of the very elderly (85 years +) is expected to increase at a faster rate than the group as a whole. Given that this group makes the heaviest demands on the health care system (particularly hospitals), it is the view of the study team that alternative, less expensive methods of care delivery must be developed if we are to meet the expected demands without massive increases in costs.

High Technology in Health Care Services

Health care technology contributes to cost increases both through the investment in the technology and through the required training of related personnel. How to ensure that only efficacious, effective and cost efficient technologies are introduced is a concern, as is the concern that these technologies do not simply become "add-on" costs.

Health Manpower

There is concern that Canada may currently have an over-supply of physicians. Because physicians have a direct effect on health care costs, an appropriate mechanism for managing and controlling this supply has been raised as an issue. While there may be an over-supply of physicians, there is also concern about the distribution of physicians, between specialties and between urban and rural locations.

Utilization

As the system is currently organized, any incentives impacting on use of services seem to be in the direction of increasing costs. Individuals want, and expect, the latest and most expensive of services. Physicians, under the fee-for-service payment system, may lack incentives to use services in a cost-efficient manner. Communities, as well, are motivated to seek additional resources and facilities for themselves.

Privatization

Privatization refers to the process of providing opportunities for the involvement of the private sector in the ownership, management and/or control of health care resources. The issue surrounding privatization is establishing what role privatization should play in the Canadian health care system.

SECTION 2
Issues in the Health Care System

In this section, issues identified in recent reports and studies and in consultations with the provinces, national organizations and with key individuals in the health care field are examined. These are the issues facing those involved in managing the health care system in Canada. For consistency, each issue is discussed according to the following framework: statement of issue, discussion of issue as outlined in prior reports and research, and comments on issue from provinces and national organizations.

Elderly

Statement of Issue

By 2006, the elderly (defined as those individuals 65 years of age and over) are projected to comprise 14.7% (4.1 million) of the Canadian population, an increase from the 9.7% (2.5 million) of the population they comprised in the 1981 Census. This rapid increase in the number (both absolute and in relative terms) of elderly people in Canada has a number of implications for the health care system:

> In 1980/81, the average length of stay in hospitals for all patients was 12.0 days. For children under 15 years of age, the average length of stay was 5.5 days. For the 65 years of age and over, the comparable average length of stay was 25.8 days. If this average length of stay for the elderly can not be reduced, substantially more hospitals and hospital beds will be required to meet the requirements of the aging population.
>
> In 1980/81, patients 65 years of age and over accounted for 22% of all hospital separations and 48% of all patient days. Again, unless these patterns of care can be changed, substantially more hospitals and hospital beds will be required to meet the requirements of the aging population.
>
> Among the elderly population, the proportion 85 years of age and over is projected to increase from 8.2% in 1981 to 11.8% in 2006. That is, there is currently an "aging trend" within the elderly group. Given that this subgroup of seniors has traditionally made the heaviest demands on the health care system, current usage patterns may under-estimate future requirements. Moreover, even with changes in health delivery patterns

> towards less dependency on institutions, the changing age structure of the elderly population may severely limit the nature and scope of new patterns of care.

Prior Reports and Research

The 1984 Canadian Medical Association's Task Force on the Allocation of Health Care Resources concentrated on the issue of the elderly. The firm Woods Gordon was commissioned to undertake an investigation of the demographic changes facing Canada over the next 40 years, and the anticipated impact on the health care system, if present methods of providing health care services were continued. On the basis of this report, and submissions to the Task Force, the Task Force concluded:

> The thrust in the redirection of health care resources undeniably needs to be in the development of community services to keep the elderly out of institutions for as long as possible, not only to reduce costs but to enhance their quality of life.
>
> Four scenarios (reduced reliance on institutional care for the elderly, reduced use of in-patient services for mental health patients, reduced length of stay in hospitals, and introduction of nurse practitioners) demonstrated that future increases in usage (and resource requirements), due to the aging of the Canadian population, could be substantially modified by shifting a portion of the demand to lower cost alternatives. Many provincial governments noted that these changes must take place.
>
> The lack of multi-level care facilities so that individuals may move freely from one level of care to another with periodic evaluation was identified. The Woods Gordon Report argued that these are essential if the right kind of care is to be available to each individual.
>
> The standard of care provided in many nursing homes was also identified as inadequate. In the short run, the report argued the problem required the implementation of strict regulations enforcing meaningful standards. In the longer run, the report suggested the elimination of care-for-profit institutions in favour of non-profit facilities.

Woods Gordon estimated the increase in resources required to meet the additional demand due to demographic change, as follows:

HEALTH SERVICE AREA	RESOURCE	% Increases 1981 /2001	1981 /2021	Add'l Annual Oper.Costs By 2021 ($M)	Add'l Cumulative Cap. Construction Costs By 2021 ($M)
General & Allied Hosp.*	Beds	44	84	7,100	17,700
Long Term Care Fac.*	Beds	63	110	4,300	12,400
Mental Health Facilities	Beds	11	35	380	360
Physician Services	Physicians	28	47	1,900	-
Home Care Services	Nurses	64	121	43	-
TOTAL				$13,723	$30,460

* These percentages represent a need for an additional 118,000 hospital beds and 276,000 long-term care beds by 2021.

Woods Gordon concluded that "in all five health care areas included in the study, more than half the projected increase will occur by the year 2001. This time period then represents a relatively short-term planning challenge for provincial governments across Canada - it is not an issue which can be postponed until the next century".

R. Evans, Professor of Economics, University of British Columbia, has argued that the increase in the numbers of elderly per se is not a serious problem. The projections indicate an increase of approximately 1% per year per capita in health costs over the 40 years from 1981 to 2021, as a result of aging alone. This increase, he argued, is well within the historical rates of increase in national income per capita. He does argue, though, that there are two problems, associated with aging, which will impact on the system.

> There will have to be a redistribution of resources away from physicians and towards long-term care institutions as a result of the aging population. Given that the number of physicians is growing, physician incomes, in constant dollars, must fall or more funds will have to be drawn into the system.
>
> The age/sex specific rates of use of hospital and medical care are not constant. They have been rising for the elderly for a number of years. The combination of advancing technology and increasing physician supply appears to be showing up in increased use and costs preferentially among the elderly. As the number of elderly increases, costs will also increase.

Comments from Provinces

In our consultations with provincial officials, all identified the issue of the elderly, their demographic increases, and related requirements for health care resources as an issue in the short run (by year 2001) or in the long run (by year 2021). Provinces are attempting to institute, or to improve, services in day care, respite care and home care programs in an effort to reduce hospital days used by the elderly population. Related goals are improving quality of life and controlling expected cost increases.

Technology in Health Care Services

Statement of Issue

Health care technology can be characterized by the speed with which new technologies are being introduced, the relatively limited "life-span" of technologies currently on the market, the degree of sophistication of the technologies and the costs associated with new developments. These characteristics of health care technology have contributed to a number of issues facing those in the health care field:

> **Funding of equipment.** High technology can be expensive. Given that the government (at both a federal and provincial level) has undertaken a large part of the funding of the health care system, a concern must be the determination of reasonable amounts to invest in new technology. Within global limits, decisions must also be made on which technologies

located in which localities, will be funded. A related concern is that where appropriate, new technology should replace existing technology and not contribute to add-on costs.

Efficacy of equipment. A major concern with the introduction of any new technology is whether it will provide a higher quality of care with less risk than existing methods of investigation. The issue is how to ensure that high technology is efficacious and that only efficacious, effective and cost efficient technologies are introduced. Related to this is a need for some coordination in the testing of new technology and some mechanism for the dissemination of results to the appropriate individuals and organizations.

Training requirements of related personnel. The degree of sophistication needed to use the new technologies has required the development of numerous training programs for specialized technicians. Establishment of appropriate training requirements, appropriate educational settings for the training, and the associated financial implications of the training are all issues related to high technology in health care. A further issue is the appropriate numbers of these allied health professionals that will be required.

Implications of high technology. One consequence of high technology is that health care providers are increasingly facing moral and ethical questions on how, and when, an individual should be allowed to die. A related issue is the 'rationing' of high technology. If all services cannot be provided to all members of a community, how should decisions on 'rationing' be made?

Results of Consultations

Prior Reports and Research

The report of the 1984 Canadian Medical Association's Task Force on the Allocation of Health Care Resources devoted a chapter to the issues surrounding the use of high technology. Various problems associated with new technology were outlined. These problems included: an expectation by patients that the doctor, using modern technology, can cure or solve any medical problem; doctors becoming more reliant on technology and losing the art of "hands on" clinical acumen; technologies being adopted whose value has not been examined; a need to organize, rationalize and channel available resources with respect to technology in the most efficient way possible; and the lack of accessibility in many areas of Canada to technologies that have been developed and adopted elsewhere. For solutions, the CMA report outlined three recommendations: (1) a need to establish a uniform set of guidelines for evaluating, acquiring, operating and funding high technology; (2) a need to rationalize and coordinate the provision of technologies, possibly through sharing facilities, both intra- and inter-provincially; and (3) an investigation of ways of controlling the use of "everyday" technologies, which contribute disproportionately to overall costs.

The issue of technology was discussed at the 1984 Health Policy Conference on Canada's National Health Care System in R. Battista, R. Spasoff and W. Spitzer's paper "Choices of Technique: Patterns of Diffusion of Medical Practices". While their central theme was to discuss the process of diffusion of medical techniques, they did raise a number of issues concerning technology. Among their points were the following observations: the diffusion of new techniques has often occurred before any formal evaluation of their effects on health outcomes; technical development promoted by private industry has been a major influence on the choice and adoption of new techniques by health care providers; very few medical procedures have been formally assessed in terms of efficacy, effectiveness and efficiency before their widespread diffusion; and there has been an increase in the intensity of use of low technology which can be attributed to the absence of cost-sensitivity amongst physicians.

Robert Evans, Professor of Economics, University of British Columbia, has suggested a refinement to the issues surrounding technology. He argues that technology per se will not necessarily lead to health care cost increases. New technology is often cost reducing. Cost increases are a result of new technology becoming "add-on" services. As well, as their effectiveness is demonstrated, and particularly as their availability increases, their range of applications steadily increases into areas where efficacy is more and more questionable.

Comments from Provinces

Provinces in general agreed to the need for assessment of the efficiency and effectiveness of high technology as well as a need to review and assess the regular non-high tech procedures. There was some concern about the cost of equipment and staff, concern about the idea of controlling these costs by devolving the services to the private sector, and some concern about comprehensiveness of and accessibility to these services.

Health Manpower

Statement of Issues

The supply and distribution of medical manpower is an issue in the health care field today. Because of the central role they play in the system, there is particular concern with regard to physicians. How many physicians a society "needs", or "wants", is a question open for debate. What is known, though, is that there is a strong interaction between the supply of physicians and total health care costs. Physicians, through their "gate-keeping" role and fee-for-service payment mode, have a very important impact on the health care system. For physician manpower, two central issues can be outlined:

> **Physician supply.** How many physicians should Canada be training and/or accepting through immigration? If it is agreed that there is an over- or under-supply of physicians, what are the appropriate mechanisms to remedy the situation. Whose mandate is this and who should be taking the lead?
>
> **Physician distribution.** Regardless of the supply of physicians, there is a concern about the distribution of physicians - between specialities and between urban and rural locations. An issue is the extent to which incentives should be used to encourage adequate physician representation in all specialities and in all locations. Determining appropriate incentives that have been shown to be effective is also a concern. Again, a related issue is the question of whose mandate it is and the corresponding question of who should be examining and acting upon conclusions.

With regard to allied health manpower and health paraprofessionals, the issues of supply and distribution are also important. In addition to these concerns, though, there are three additional issues:

Baccalaureate training. The nursing profession has established a goal of having all new nurses trained at the baccalaureate level by 2001. If this goal is acted upon, there will be significant implications for training programs in universities and colleges and asignificant impact on hospital budgets.

Fee-for-service. Numerous paraprofessional groups have made requests for a fee-for-service payment structure similar to that available to physicians. If these groups do gain the right to a fee-for-service payment mode, there will be significant cost implications for the health care delivery system and a significant change in the way health care is delivered.

Implementation and administration of health legislation. Health care professionals are increasingly requesting, and receiving, exclusive "scope of practice" through provincial legislation. Such legislation has cost implications for staffing requirements (e.g. staff mix of nursing assistants, nursing attendants and registered nurses) and for training requirements (i.e. proliferation of manpower groups, each with increasing educational requirements).

Prior Reports and Research

The Honourable Emmett Hall, in his 1980 report Canada's National-Provincial Health Program for the 1980's, referred to the concern about the supply of doctors and doctors' expectations for "reasonable" income levels. He stated that the "doctor supply dilemma must be addressed, otherwise there will be increasing conflict between doctors and provincial paying agencies over fee schedules". His suggested solution to the "doctor supply dilemma" was a call for the federal and provincial and territorial governments to set up and fund a medical manpower survey in association with the Canadian Medical Association. He further suggested that the manpower study give special attention to under-supply in certain specialities and in certain regions.

The federal government, in consultation with the provinces, has in fact examined physician manpower in Canada. In late 1982, the Federal/Provincial/Territorial Conference of Deputy Ministers of Health directed the Federal/Provincial/Territorial Advisory Committee on Health Manpower to undertake a short-term study on medical manpower in Canada. A preliminary report of the Committee was released in 1985. The study concluded that a comparison of physician supply and requirements for 1980 and 2000 indicated an overall 2.2% surplus of 828 physicians in 1980, which was projected to increase to a 12% surplus of 5,982 physicians in 2000. The projected surplus was estimated to be concentrated in general practice and medical specialities, with projections of shortages for surgical and laboratory specialities. The study also noted that the projected physician supply was conservative in that the increase in Canadian medical school enrolments which has taken place in recent years was not incorporated in the 1979/82 averages used in projecting supply.

In response to the projected surplus of physicians, the study made 11 recommendations. The recommendations included reducing the annual entry of "selected" immigrant physicians to Canada, reducing the annual addition to Canadian physician stock from physicians trained abroad, reducing the number of physicians practising in Canada on temporary visas, reducing the annual output from Canadian post-graduate training for general practice stock, while increasing surgical and laboratory post-graduate training positions, reducing the output from Canadian post-graduate training to medical specialties stock and reducing the Canadian medical school enrollment (entry class) effective 1985. The Advisory Committee on Health Manpower's study also recommended that the specialty-specific number of post-graduate training positions be rationalized, including consideration of regional requirements for selected programs in accordance with present and projected shortages (or surpluses), that federal and provincial staff explore mechanisms to ensure visa trainees return to their country of origin and that effective measures be adopted to ensure physicians establish only in areas of demonstrated need for medical services.

Comments from Provinces

In some provinces there is a concern about the shortage of specialist manpower and the under supply of general practitioners in remote areas. However, most provinces are concerned about the general overall over-supply. There are attempts to cap the system by limiting entry into and access to the fee schedule. Other provinces have instituted quarterly caps on income. Some problems were identified in the area of interprovincial payments for physician services. Some provinces are also looking at a salaried approach.

Utilization

Statement of Issue

There is widespread concern in the health care system about a rise in health care costs. This concern has been addressed by looking at the components of the cost increases, namely, the elderly, technology and the cost pressures stemming from manpower issues. The other factor impacting on health care costs is utilization. The issues surrounding utilization are as follows:

> As the system is currently organized, individuals expect the very latest and most expensive of services. There are also increasing pressures from consumers to want these services delivered to them in their immediate area and delivered to them at their demand. These pressures contribute to increasing health care costs.
>
> For physicians, with the current fee-for-service payment mode, there are no incentives to use services in a cost-efficient manner. As well, the incentive to maximize income will generate health care costs for the system.
>
> Communities actively seek the best facilities and resources for their residents; these pressures also contribute to increasing health care costs.

Prior Reports and Research

In 1985, Denis Roch, Robert Evans and David Pascoe published a review of medicine in Manitoba entitled Manitoba and Medicare, 1971 to Present. This report looked at physician and institutional care in Winnipeg and Brandon and concluded that the decade has seen a significant change in the patterns of practice by physicians. After adding 25%

more physicians, and with no increase in population, there was no significant difference regarding the average gross billing for individual physicians in 1981/82 as compared to 1971/72 (after adjusting for fee increases). The study concluded that there was no evidence to suggest that the medical services system has any inherent checks and balances within it which would drive down or maintain real total medical services expenditures in light of an increasing number of physicians relative to population.

Comments from Provinces

Provinces were concerned about the open-ended access to the health care system. Some have instituted user fees for the use of institutional services, others are considering user charges for misuse of proper level of service (i.e. emergency ward instead of physician's office). There was general concern about the use of diagnostic tests and an attempt is being made to rationalize. Some provinces are also attempting to rationalize entry into the extended health care facilities by establishing one point of entry into the system (i.e. home care).

Privatization

Statement of Issue

Privatization is the process of providing opportunities for private sector involvement as a supplement to the traditional reliance on public sector management and financing within our health care system. The issue surrounding privatization is establishing what role (kind and extent) privatization should play in the Canadian health care system. With regard to privatization itself, the issues center on what objectives should be achieved (i.e. increased efficiency, provision of additional funds, promotion of competition) and how these objectives should be reached.

Areas of privatization include the following:

Financing Services and Facilities. This represents the infusion of private funds into the system. Examples aimed at individuals would be extra billing and user fees for hospital services. The rationale for these practices is to make the patient responsible for paying for at least a part of the use of services. At a hospital level, the Canadian Hospital Association estimates that hospital auxiliaries and foundations raise hundreds of millions of dollars each year from philanthropic sources ($300 million in 1984). As well, debt and equity capital may be made available by private companies.

Ownership of facilities. Ownership of facilities ranges from public ownership in the hospital sector to a mix of private non-profit and private-for-profit ownership of long-term care facilities. The rationale for private ownership is the ability of private firms to tap into pools of capital dollars coupled with management expertise.

Managing elements of the system. This represents the use of private management companies contracting to manage a hospital department (i.e. food, laundry services) or even an entire hospital. Elements of a province's health care administration system could also be contracted to a private management company. The rationale for contracted services is the perception of more efficiency on the part of private owners and an attempt to reduce costs and person-years in some sectors of the public system.

Provision of services. This already exists to a large extent (e.g. physician's services, long-term care, home care services).

Prior Reports and Research

A study done for the Minister of Health and Welfare Canada in June 1985 found no significant support for privatization of the health care system from providers or consumers; but private sector involvement, in limited ways, was acceptable. It was also found that much could be done to strengthen and revitalize the institutional management already in place, without changing its nature. It was concluded that economic pressures have led to a willingness to consider reasonable changes, which provides room for experiment in Canadian health care delivery techniques.

Private Hospitals, a working document prepared by the Research and Development Department of the Canadian Hospital Association in September 1985 concluded that privatization was inherently neither good nor evil. Whether it is appropriate depends on how it is implemented and the objectives that are being pursued.

Privatization in the Canadian Health Care System, a study done for Health and Welfare Canada by G.L. Stoddart and R. Labelle, McMaster University in October 1985 concluded that the privatization debate is primarily one of ideology as opposed to one of hard evidence on either side. It was felt that energies should focus on analysis of system performance and the mechanisms which might improve it. It was felt that the blueprint for a perfectly competitive set of private markets that smoothly yield efficient production and optimal resource allocation patterns was not applicable to the issue of the Canadian health care system. The two pillars anchoring the privatization argument appear to be supplements for financing and the management of institutional care.

Comments from Provinces

In a few areas of the country, privatization appeared to be primarily a philosophical issue. However, in most areas, attention was given to practical applications. Some provinces were willing to absorb the penalties imposed by the Canada Health Act because the benefits of individual charges outweighed the losses accrued through penalties. Some provinces are also following closely the results of private management at the Hawkesbury General Hospital where deficits have been eliminated and surpluses established. Some provinces are looking at a management system of patient classification called Diagnosis Related Groups (DRG's) which provides a framework to understand and measure hospital care, treatment and services, and to bring about changes in medical care practice patterns. One province is attempting to control through legislation, physician entry into the medicare fee schedule.

SECTION 3

Indicators of the Health Care System and Health Status of Canadians

Demographics

There were roughly 2.5 million Canadians 65 years of age and over as of June 1, 1981. By the turn of the century it is projected there will be 3.4 million Canadians aged 65 and over, an increase of 48%. By the year 2000, nearly 12% of Canada's population is expected to be at least 65 years old (compared to a 1981 per cent of 9.7).

Within the elderly subgroup, particularly rapid growth is expected for those at least 80 years old. There were roughly 436,000 such Canadians in 1980 and it is projected there will be approximately 777,000 at the end of the century, an increase of more than 75%.

A striking feature in the changing profile of Canada's older population is the substantial and growing imbalance in the number of men and women. Since 1961, women have been the more predominant of the two sexes in the population aged 65 and over. Over one-half of Canada's women aged 70 and over are widows.

Dependency ratios give a measure of the proportion of the population under 17 years of age and over 65 years of age compared to those between 17 and 65 (i.e. the ratio of the economically "dependent" to the economically "independent"). In 1985, the total dependency ratio was 58.6, which is projected to decline to 52.6 by 2006. However, within the total dependency ratio, the aged component is projected to increase from 18.8 to 25.2. At a provincial level, four provinces (Quebec, Ontario, Manitoba and British Columbia) are projected to have aged dependency ratios over 25.0 by 2006.

Health Status of Canadians

Canada has one of the highest average life expectancies of any country for both males and females: in 1982 life expectancy at birth for males was 71.9 and 79.0 for females. It also has one of the largest life expectancy differentials by sex: 7.1 years.

In terms of regional disparities in life expectancy, these differences have been decreasing since 1951. However, the difference between provinces with highest life expectancy (Prince Edward Island and British Columbia) and those with lowest life expectancy (Quebec and Nova Scotia) in 1982 was still significant, 1.9 years for males and 2.1 years for females.

Life expectancy in Canada's three largest cities is considerably higher than the Canadian average. Life expectancy in rural areas is considerably below the average. Among urban communities of less than one million population, differences in life expectancy are not appreciable.

In Canada today, most of the leading causes of death are heavily influenced by environmental and behavioural risks. Accidents, violence and suicide, for instance account for 55% of deaths between ages 15 - 24 and 45% of deaths ages between 25 - 44. In 1983, ischemic heart disease was still the single most important cause of death for males and females in the 25 - 74 age range. However, in the period 1969 to 1983 the age standardized mortality rate for ischemic heart disease declined by 32.1% for males and 37.0% for females. Over the same period, the male cancer mortality rate increased by 6.4% and the female rate decreased by 1.7%.

Utilization of Health Care Services

In the 1977/78 fiscal year, patients spent over 51 million days in public hospitals, including more than five million days in mental institutions, for an average rate of 2.19 days per person.

The rate of patient-days in hospitals varies by sex and age in Canada. In the 15-24 and the 25-44 years age groups, the rate for women is double that for men, which can be largely explained by childbearing. Men experience much higher rates in the 45-64 year age group due to the greater tendency of men to suffer heart ailments than women. Both men and women over 65 years used hospitals at a rate of 824 days of care per 100 population.

The length of stay in hospital varied significantly by age group. For persons up to 44 years of age, stay in hospital averaged about one week. In the 45-64 year age group, the average stay increased to 12.3 days, those 65 years and over averaged nearly 25 days in hospital per stay.

In terms of rates, separations per 1,000 population have shown a downward trend since 1976. In 1976, there were 158.66 adult and children separations per 1,000 population. This had fallen to 145.45 separations per 1,000 population in 1983/84. All provinces, with the exception of Nova

Scotia, experienced this decline. While separations have fallen, patient days have increased over the same time frame. In 1976, there were 1954.71 adult and children patient days per 1,000 population. In 1983/84, this rate had increased to 1997.86. This increase in the Canadian rate is attributed largely to Quebec. Newfoundland, Prince Edward Island, Ontario, Manitoba, Alberta, Saskatchewan and British Columbia showed a slight decrease in the rate of adult and children patient days per 1,000 population.

For the fiscal year 1983/84, there were approximately 145 million medical consultations and visits in the 10 provinces, an average of about six per capita. The rate of office visits was considerably higher in central Canada than in the other regions of the country. One possible explanation for this difference is a higher physician/population ratio in these regions leading to easier access to physicians' services. On average there were 193 surgeries for every 1,000 Canadians; 100 minor and 71 major surgeries performed for every 1,000 Canadians and 22 obstetrical interventions.

The 1978/79 Canada Health Survey indicated that 76% of Canadians made at least one visit to a medical doctor during the course of the year. Many had multiple visits, with about 25% reporting three to nine visits to a doctor and another 9% indicating 10 or more visits.

Resources in the Health Care System

Physician manpower supply, requirements, distribution and costs have been examined for many years in Canada. From 1961 to 1984, the number of active civilian physicians (excluding interns/residents) increased by 130% from 18,462 to 42,400. The population increased only by 39% over the same period, with the result that the population to physician ratio decreased from 995 to 596. If present trends continue, the growth of physician supply will continue to exceed population growth.

Provincial distributions of active civilian physicians, excluding interns and residents, differed significantly in 1984. Nova Scotia, Quebec, Ontario, Manitoba and British Columbia had relatively low population to physician ratios (under 610). In contrast were Prince Edward Island, with a comparatively high ratio of 818 persons and New Brunswick with 830. In Ontario, the population per physician (including interns and residents) varied significantly in

1977 from 1,450 in communities of under 10,000 to 874 for communities between 10,000 to 24,999. In contrast, the ratio of 522 in population centres of 500,000 or more indicates the preference of physicians for large cities.

The number of active dentists in Canada increased by 50% from June 1969 to 1978, far ahead of the 13% growth in population during the same period. In 1978, Canada had 44 dentists per 100,000 persons. The ratio of dentists to population differed significantly by province. Newfoundland had the lowest ratio, 20 to 100,000, and British Columbia had more than three times that ratio, or 62 dentists to 100,000 persons.

Nurses represent about two-thirds of all health manpower in Canada. The number of registered nurses employed in nursing increased by 55% from 104,258 in 1970 to 161,125 in 1978, while the Canadian population grew only 10%. In 1978, the ratio of nurses per 100,000 persons was 683; it varied from 555 in British Columbia to 793 in Alberta. Hospitals and related institutions have always employed the majority of nurses. The percentage working in hospitals remained relatively stable during the period 1970 to 1978, increasing only slightly from 82% to 84.7%.

In 1983/84 there were a total of 1,206 public general operating hospitals in Canada, with an approved bed complement (adults and children) per 1,000 population of 6.58. The approved bed complement varied across the provinces from a high of 8.08 in Quebec to a low of 5.35 in Newfoundland (1.98 in N.W.T.). The approved bed complement per 1,000 population has shown a slight downward trend from 1976. The rate for Canada was 6.75 in 1976.

Priority Target Groups

Elderly

The number of elderly will increase significantly in the next decade. This population segment accounts for a relatively high percentage of the usage of the health care system.

Native People

It is projected that the native population will continue to grow at a faster rate than the population as a whole. The health status of native peoples is significantly lower than that of the total population.

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Native People

It is projected that the native population will continue to grow at a faster rate than the population as a whole. The health status of native peoples is significantly lower than that of the total population.

Death rates for Indians, despite improvements over the past years, remain well above the national average. For all age groups (except those over 65, where the Indian rate is only slightly higher than the national one), Indian death rates range from two to four times the national average.

Disabled

The estimated number of disabled persons varies according to the definition of the term "disabled", the method used to collect data, the purpose and interpretation of the data and the time frame involved.

The Canada Health Survey estimated that 12% of the population has some form of disability, defined as the limitation to one's normal activity due to poor health. The prevalence of disability increases with age: 3% of all Canadian children, 11% of all adults of labour force age, and 30% of all Canadians 65 years of age and over are disabled. As measured by degree of limitation, 2% of the population can be expected to experience severe disability, moreover the severity of disability tends to increase with age. Mental disorders are frequent and more numerous among groups having the lowest levels of income and education.

Health Care Costs

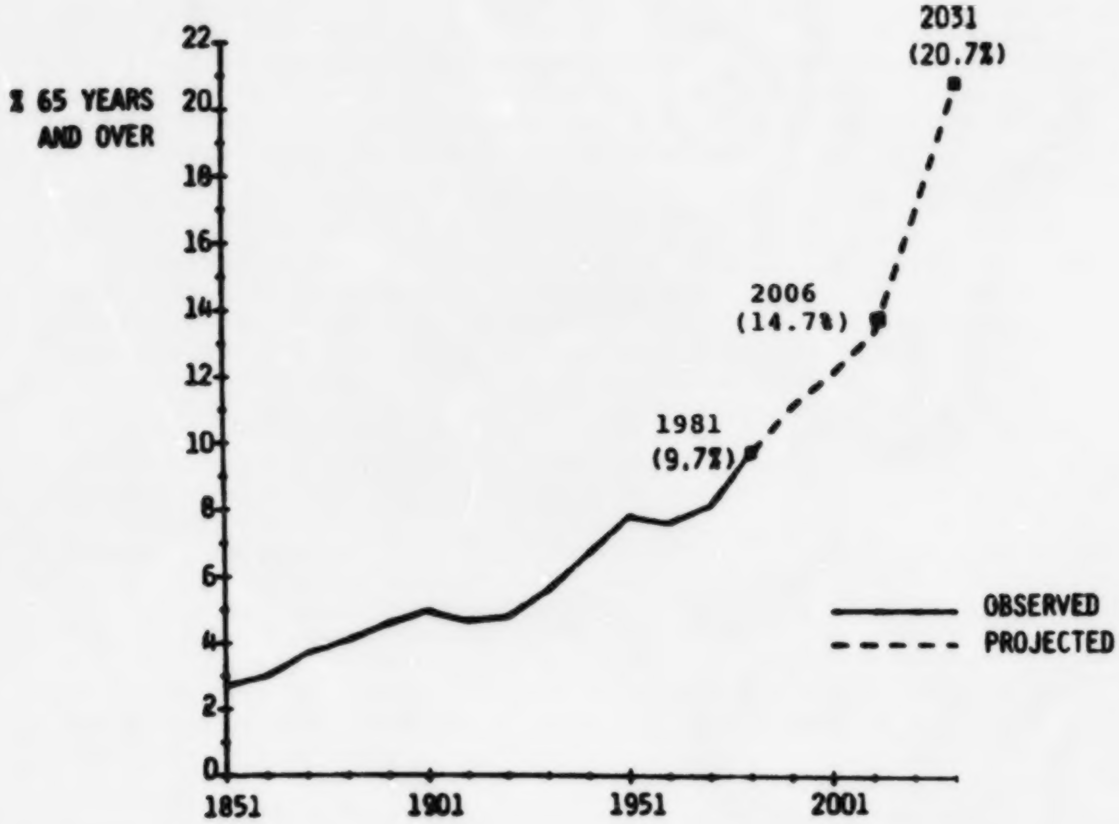
The aggregate health care bill in Canada, including both public and private sector expenditure was about $36 billion in 1984. The private sector accounts for about 25% of this amount. Provincial and local government health spending is now close to $1,000 for every man, woman, and child in the country.

Over the last six years provincial health costs have more than doubled from $12.5 billion in 1978/79 to an estimated $26.1 billion in 1984/85. During the same period the overall cost of living as measured by the CPI increased by 65%.

The share of total economic activity accounted for by health spending has increased over time. Health spending (public and private) as a per cent of Gross National Product rose from 7.3% in 1970 to 7.6% in 1981 and 8.4% in 1982. It is generally believed that the sharp jump in 1982 had less to do with health spending than with the fall-off in economic activity in this recession year. However, some health economists expect that final figures for 1983 and 1984 will confirm that the ratio has held steady along the new 8% plateau reached in 1982.

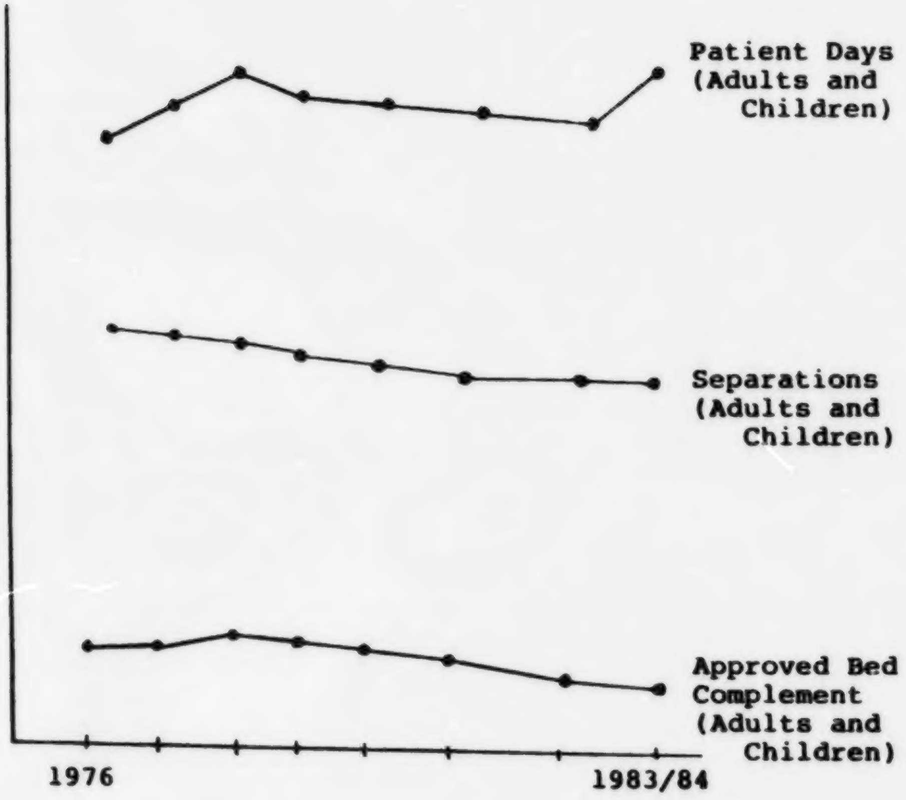
Compared to other OECD countries, Canada is above average in the percentage of GNP devoted to health expenditure. Canada's ratio of 7.6% in 1981 compares with an OECD average of 7.3%. The ratio is 7.5% in Australia (1980), 6.9% in Switzerland (1980) and 6.7% in the United Kingdom. The United States devotes 9.7% of GNP to health, Sweden 8.3% (1980), and Denmark 8.1% (1979). Given the jump in Canada's ratio in 1982 to 8.4%, Canada may very well move up in terms of this international ranking.

PERCENTAGE OF ELDERLY IN THE CANADIAN POPULATION, 1851 - 2031

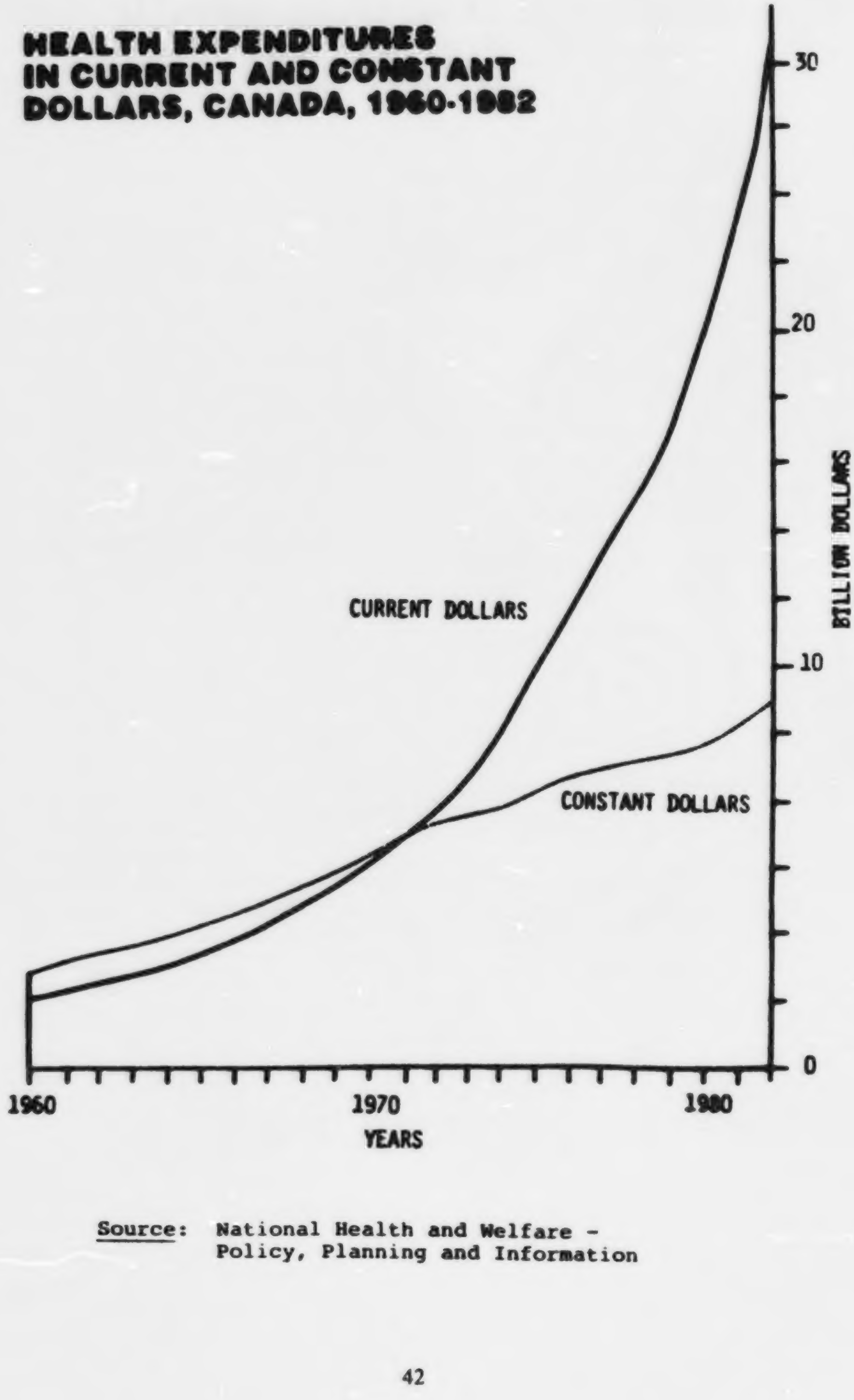


Source: National Health and Welfare - Policy, Planning and Information

HOSPITAL UTILIZATION, CANADA, 1976-1984
RATES PER 1000 POPULATION



Source: National Health and Welfare -
Policy, Planning and Information



HEALTH EXPENDITURES
IN CURRENT AND CONSTANT
DOLLARS, CANADA, 1960-1982

Source: National Health and Welfare -
Policy, Planning and Information

FEDERAL/PROVINCIAL RELATIONSHIPS: AN EVOLUTION

SECTION 1
Introduction

The study team feels it important that an overview perspective as it relates to the Canada Health Act, Established Programs Financing Act and the health care system in Canada be provided. It is also of the view that longer term considerations must be taken by the federal government.

The attached papers on the Established Programs Financing (EPF) and Canada Health Act (CHA) provide details of these federal programs, together with observations concerning the major issues to be considered in reviewing them.

Government sponsored health care in Canada can now claim a long history, and one which Canadians view as successful. The system has had a natural and progressive evolution which has proved successful and highly relevant to the Canadian context. Begun in British Columbia and Saskatchewan in the late 1940's and early 1950's, and then established as a national program in 1957 with the Hospital Insurance and Diagnostic Services Act. The system developed further with the introduction of the Medical Care Act in 1967, and can now be characterized as a mature system insofar as hospital and medical services are concerned and of experimentation in new technologies and new delivery methodologies.

There has also been a remarkable evolution in terms of the technology directed to illness treatment in this same period of time. Procedures and treatments never even dreamed of in the 1950's and 1960's are developing at an ever-increasing rate. The underlying technology of the health system and of the funding system in 1985 bears little, if any, resemblance to that which prevailed when national health insurance programs were first designed.

With respect to inter-governmental relationships, the central question has become (or is) the appropriate role that the federal government should play in the future in health areas under provincial jurisdiction, specifically, health insurance - and stemming from that, the mechanisms for, and levels of, federal funding to be employed. An overview of changes that have taken place, namely from 50/50 cost sharing to block funding, serves to highlight governmental attempts to match funding systems to changes in the health care delivery system itself. These changes have not taken place without conflict, and it is the belief of the study team that conflict can be traced, in part at least, to the fact that the health care system and the funding system have not evolved evenly.

From the provincial perspective primarily, but also from the federal perspective, major issues which require addressing are:

1. Escalating illness treatment costs which have, over the course of the past decade, outstripped economic indicators.

2. The converse - namely government revenue rates of increase which have not matched rates of cost increase in the system.

3. The imprecision of definition with regard to those fundamental criteria which have formed the foundation for federal health insurance legislation, namely universality, accessibility, portability, comprehensiveness, and public administration.

4. The very real difficulties of dealing with a system where public expectations seem to be limitless and provider access to public funds is, in some respects, unbridled.

5. In the context of the foregoing, how to move to more cost effective ways to deliver services while adhering to national criteria.

From the federal perspective primarily, but also from the provincial perspective, the major issues appear to be:

> The requirement to ensure, in the national interest, that the current system retains the five underlying criteria as noted above.
>
> The need to somehow contain federal liability in the presence of a large federal deficit.

The need to more clearly address issues which relate to disease prevention, health promotion, and the development of a greater sense of individual responsibility for one's state of health.

It is in the context of the foregoing that the study team feels additional issues to be considered are as follows:

The need to address the central issue of ensuring that responsibility, authority and accountability for the current "illness treatment system" are appropriately aligned. Currently, the provinces have full management responsibility, authority and accountability for cost generation, and the federal government has a major responsibility for the provision of fiscal resources and major authority under the Canada Health Act with respect to the construct, in broad terms, of each provincial system.

The critical need to reduce conflict between the two levels of government in the health field.

The need to recognize and accommodate the impact of system evolution and direct funding evolution so that they are not in opposition.

It is as a result of the foregoing, and of the study team's firm belief that the issues surrounding EPF and the Canada Health Act are inextricably linked to each other, that this paper investigates the possibility of new directions.

SECTION 2

A Question of Fundamental Choice

Options available with respect to EPF and the Canada Health Act are as follows:

The evolution option, whereby a new, and more appropriate, relationship is defined and established between the two levels of government.

The reversion option for EPF whereby the fiscal arrangements are directed in such a way as to move more towards the original "50/50" basis of cost sharing with all that that implies.

Status quo, retaining all features of EPF and CHA as they currently exist.

Evolution Option

Under this option, the federal government would continue a level of cash funding for health insurance that would ensure that the Minister of Health has, and is seen to have, by Parliament and the provinces, a meaningful and legitimate role in the national health care field.

Subject to the above, a substantial portion of EPF to become unconditional in form, unrelated to health and post-secondary education. To the extent possible, the cash portion of the EPF package would be converted into additional income tax room for the provinces.

Develop federal/provincial agreement(s) which would;

- define more precisely the national standards/criteria of health insurance services to be provided by provinces; and
- provide a mechanism to monitor and ensure that standards are, in fact, met.

Amend CHA appropriately, to eliminate unnecessary compliance and other measures. New legislation or an amended CHA would be needed to authorize the Minister to enter into the envisaged agreements.

The intent of this option is to reduce the level of friction between the two senior levels of government on matters of finance and jurisdiction and to permit for positive collaboration on the issues facing our health care system.

Pros

Maintains the capacity of the federal Minister of Health to exercise his role in the national health care field.

Separating EPF arrangements from "health" accompanied by collaborative approach to maintenance of national health insurance system would eliminate many sources of friction in current situation and, therefore, should encourage development of an environment conducive to discussions of all health issues of national and intergovernmental concern.

Federal government would be less exposed to provincial charges of interference and constitutional impropriety.

Provinces would become more fully accountable to the public for administration and cost-effectiveness of their health services programs.

Inflexibilities engendered by the CHA would be eliminated, and program changes would not be inhibited - as they may now be - by the ongoing argument about what provinces are doing with the federal transfers "for health".

Federal government would have more energy and freedom to pursue national health priorities.

From the provinces perspective, the greater the tax room under EPF, the less susceptible the package is to federal restraint exercises.

Cons

Full financial disengagement from provincial health services could lessen the Minister of Health's capacity to influence his provincial colleagues.

Potential public and/or political perception that the federal government is withdrawing from overall monitoring and financial role in national health insurance.

Reversion Option

Under this option, the system would return to some form of cost-sharing in provincial health insurance programs; e.g. federal sharing of defined "eligible" costs; or, per capita transfers escalating at national rate of growth for defined "eligible" costs.

Pros

Possibly provide some additional funds for provincial health programs (as eligible costs increase).

Might be welcomed by provincial and federal health ministers wishing to see health budgets receive more leverage in competition for funds.

Could strengthen the federal Minister of Health's capacity to influence provincial programs.

Cons

Return to the shortcomings of the previous shared-cost arrangements, i.e. charges of interference, imposition of inflexibility in programming, wrangles over costing questions, requirements for audited reports on eligible costs, etc.

Would move federal role in a direction away from that which has been evolving and would increase federal exposure to cost increases.

Negative reception by provincial governments (Finance Ministers) as it would tend to limit their budget flexibility, particularly in the health field.

Status Quo Option

EPF remains in place "as is".

Minister of Health and Welfare Canada continue current cooperative and flexible approach to the CHA and with bilateral discussion and resolution of problems.

Pros

Would continue substantial federal contribution for health purposes.

Some improvement in federal/provincial environment as Minister of Health and Welfare Canada continues to demonstrate flexibility, and as the Minister moves into discussion of a better longer-term federal/provincial collaborative approach to health matters.

Continue to limit federal exposure to health cost increases.

Cons

EPF with its designated "health" dollars would continue to invite arguments on share of costs being borne by the federal government. Success in addressing health questions jointly could be negatively affected.

Always a chance that Minister of Health and Welfare Canada will be driven, by the reporting requirements to Parliament and other provisions of the CHA, to a more rigid approach, with consequential increases in federal/provincial tensions.

Provinces would continue to be uncertain about the future stability of EPF-health transfers.

The study team recommends to the Task Force that the government consider the evolution option, not only because it best allows for resolution of the issues identified, but also because there is a sense of inevitability that, over the next decade at least, evolution will take place. It would be preferable that such evolution be the result of a conscious and comprehensive process of definition as opposed to a reaction to crises.

SECTION 3
Pursuing the Preferred Option

The study team is of the opinion that, in pursuing an option of fiscal and system evolution, it is necessary to identify clearly the central and essential principles upon which the federal government would be willing to consider any changes. These principles are as follows:

Maintenance of the five fundamental criteria of our health care system - namely, ACCESSIBILITY, UNIVERSALITY, COMPREHENSIVENESS, PORTABILITY, AND PUBLIC ADMINISTRATION - must be ensured and, in the national interest, the federal government has a right and obligation to monitor the system in this regard.

The principle of interprovincial fiscal equity for these social programs (which is at the very basis of Canada as a nation) must be retained at least as it currently exists.

The federal government has a legitimate major leadership role to play in health promotion, strategies for disease prevention, and the encouragement of greater levels of individual self-responsibility for health among all Canadians.

Assuming the acceptance of these principles, the study team then proceeded to identify possible mechanisms for evolution of federal/provincial relationships whilst ensuring that the principles would be protected. The following sections present the team's thinking in terms of items which might form the basis for intergovernmental discussions over the next few years.

Ensuring the Five Criteria

Currently, ensuring that the five criteria of Canada's health care system are complied with by provinces is highly dependent upon the ability of the federal government to monetarily "penalize" provinces. With a mature social progam, and in the interests of cooperative federalism, it is the study team's belief that this is not always an appropriate and necessary mechanism. Firstly, any province which deliberately violates these fundamentals would surely and quickly be brought to task by its own public and electorate; in an age of social advocacy, this is an effective first line of defence. Secondly, moral suasion, particularly when it is applied to a mature and universally accepted social program, can be most effective, as can federal government advocacy. Thirdly, it will always be within federal jurisdiction to legislate conformance after the fact if absolutely necessary, and, in this instance, inter-provincial pressures could become substantial for an offending province. Finally, the opportunity exists at the outset of proposed negotiations, for provinces to formally commit themselves to the maintenance of a viable basic national health care system.

In order to ensure maintenance of the five criteria, the federal government must be in a position to constantly monitor changes that take place in provincial programs. There are a variety of mechanisms for such monitoring including, but not limited to, the following:

Review of regular reports submitted in accordance with agreements with the provinces.

Review of complaints in the media and from individual Canadians.

The establishment of a small but powerful secretariat under the Minister of National Health and Welfare charged with responsibility for monitoring, analyzing and advising on such changes as may take place in provincial delivery programs. Such a secretariat could also act as a source of information exchange between governments in terms of promising positive changes or experiments.

The establishment of an arm's length agency along the lines of the Economic Council of Canada, one of whose responsibilities might be to report to the Minister of National Health and Welfare on the state of the country's health care system. The study team is particularly attracted to the potential value of the concept of a Health Council of Canada. Such a body, constituted on an arm's length basis, with a membership of outstanding Canadians, and a small but expert secretariat, might prove exceedingly useful, not only as a monitoring agency, but also as a focus for the analysis, the development of new delivery concepts, and catalysis of a greater degree of self-responsibility amongst Canadians through public education about our health care system. A key concern of the study team, if the concept of such a Council was to find favor, would be that its membership must not be constituted so as to provide specific representation of key elements in the current delivery system.

The foregoing represent ways in which the Minister might monitor the state of the health care system in the national interest - the list is not intended to be comprehensive and further options are undoubtedly available.

Ensuring Interprovincial Equity

The study team examined a number of alternative options in moving towards the long term goal. The maintenance of interprovincial equity was an important consideration throughout this examination.

In considering an "all-tax" option for EPF transfers, for instance, it was concluded that cash adjustment payments of some kind would be necessary to avoid significant losses in less wealthy provinces.

We have already stated a preferred option for changing federal/provincial fiscal arrangements. Whatever arrangements may ultimately be negotiated, the study team is convinced that interprovincial equity must be protected, just as it is convinced that a new relationship must be negotiated, one which specifically places major responsibility and accountability for revenue generation squarely with the level of government which has control of health expenditures.

The study team suggests that negotiations at the Ministerial level between the provinces and the federal government begin as soon as possible with a view to, among other things, re-defining the intergovernmental fiscal arrangements for health in a manner which will better align the fundamental management issues of responsibility, authority and accountability.

Promotion and Prevention

As our present "illness care" system has evolved, it has become mature and established as a national social system. But, as agreed by most observers, the emphasis is indeed on the treatment of illness rather than on addressing some of the root causes of illness; the outlook becomes short-term and the utilization of resources somewhat inefficient.

As a result, the pressures of provider groups and agencies, and the very real economic conflicts presented to provinces, have served to detract from the central requirement; the promotion of health. The most significant effort towards advancing this cause has come from the federal level in past years.

The study team has put forward specific suggestions with respect to health promotion elsewhere in this report, which require involvement of provincial governments. But most importantly, it emphasizes the leadership responsibility of the federal government in any campaign to legitimize lifestyle changes, health promotion, illness avoidance and, particularly, the "selling" of the concept that each individual Canadian has a major self-responsibility to advance the cause of his/her own health and to utilize the illness care system with a high degree of responsibility.

A Process for Change

Key to the foregoing strategy is the necessity for strong federal leadership, at the political level, in initiating and successfully concluding the negotiations necessary to establish new relationships important to advancing the directions indicated., It is our view that the federal government must conduct the negotiations in a meaningful way, with a view to achieving consensus. This responsibility cannot be delegated.

These negotiations towards a new direction should begin at the earliest possible moment, for it is unlikely that major changes can be made, particularly with respect to fiscal arrangements in a time frame of less than five years.

As a result, a transition period of some five years will have to be dealt with.

The Transition Period - 1987/92

It will take some time to move from the current situation to the envisaged long-range federal role(s). Extensive consultations with provinces, as well as between the federal Ministers of Health and Finance would be required. A useful timing for staged changes would be the context provided by quinquennial fiscal arrangements negotiations. These negotiations are just beginning and will end late next year for the five years 1987-1992. It is suggested that, assuming the proposals for the long-run are accepted, some changes in EPF and other federal/provincial health related activities could be instituted, say, on April 1, 1987, and the next five years could then be used by the Minister of Health and Welfare to bring about agreement on the long-run re-orientation.

During this same five-year period, the following needs must be addressed:

- stability in funding
- the federal deficit
- flexibility and compromise
- assistance in experimentation.

The study team recommends to the Task Force that the government consider the following as a mechanism for governing federal/provincial relationships in health to 1992.

Eliminate the split in EPF between health and post-secondary education or, failing that, make the split on a more realistic basis.

Fix for a five-year period EPF arrangements, appropriately modified as above, by means of legislative amendment and preferably confirmed through federal/provincial agreement. This implies no changes without provincial consent.

The Minister of Health and Welfare enter into bilateral discussions with the provinces to jointly develop a flexible approach in dealing with problems under the Canada Health Act.

Flexibility could be exercised in the interpretation of the Act:

the Minister could be lenient in the time allowed for provinces to work out arrangements for satisfying the portability provisions;

the Minister could agree to minimize information requirements under the Act.

Provide funding to provinces for one or more of the following purposes (cost-shared or otherwise):

community based health care initiatives (as mentioned in the Throne Speech);

capital projects targeted to the health care needs of the elderly;

alternative low-cost health care delivery mechanisms.

Pros

Five-year term for EPF is more consistent with the original intention in 1977 that EPF was to be a permanent arrangement. (In the 1977/82 period arrangements were effectively locked-in for a five-year period by the requirement of three years' federal notice to terminate the arrangement and the need for provincial consent to changes during the first two years.)

Would restore stability in health and post-secondary education financing for provinces.

Discontinuing the legislated split of EPF would firmly re-establish EPF as block funding for both health and post-secondary education, rather than separate transfers for each function. This return to true block funding would represent an evolutionary step towards the severing of EPF funding relationship to health care.

Eliminating the breakdown of EPF between health and post-secondary education would remove the current readily available data used for the time-consuming debate on what "share" each government pays respecting these functions.

If the termination of the split is unacceptable, a division based on current provincial spending priorities between the two functions would at least be more realistic.

A more progressive interpretation of the Canada Health Act would give added flexibility to provinces in meeting health cost pressures and would ease the administrative requirements at both levels of government.

Directed federal funding would stimulate the development of low-cost alternatives to hospital care.

The three elements of this option (EPF, CHA, directed funding), taken together, would do much to alleviate irritants between the two levels of government and thus improve the climate for negotiations towards a new long term approach to health care issues and remedies.

Cons

From the federal finance point of view, the five-year term for EPF limits fiscal manoeuverability at the federal level by protecting these transfers from the ongoing federal restraint exercise.

Ending the EPF split would complicate the process of the federal ministers reporting to Parliament on the effectiveness of spending of EPF monies.

Relaxed enforcement of CHA provisions could be perceived by some as a retrenchment of federal commitment to preserve Medicare.

Circumstances could drive the Minister of Health and Welfare to a more rigid approach to administration of the CHA, with undesirable effects on federal/provincial (health) relations.

ESTABLISHED PROGRAMS FINANCING (EPF)
HEALTH-TAX POINT TRANSFER
(Health and Welfare Canada)

OBJECTIVES[1]

To transfer fiscal resources to the provinces with the primary objective of ensuring maintenance of provincial health insurance programs that meet certain federal/national criteria and other conditions; criteria and conditions are set out in the Canada Health Act, 1984.

Other objectives relevant to this examination are some of those enunciated by the federal government when EPF was negotiated in 1976. They are:

a. the federal government should continue to pay a substantial share of (program) costs;
b. there should be greater equality between provinces in the transfers, i.e., equal per capita rather than the varying amounts under the shared-cost arrangements;
c. funding should be more stable (for both federal and provincial governments) through more permanent arrangements;
d. the provinces should have flexibility in the use of their funds in the fields of health and post-secondary education;
e. continuing joint policy discussions should exist in the health and post-secondary education fields.

BENEFICIARIES

All provinces and territorial governments and, through them, virtually all residents of Canada.

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[1] Basically, these objectives parallel those set out by the federal government when EPF was negotiated in 1976. The first objective, however, has been written in the light of the "PURPOSE" set out in the Canada Health Act.

AUTHORITY

Part VI of the Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, 1977 as amended; and

The Canada Health Act, 1984.

RESOURCES

Administration rests with the Minister of Finance (calculation of transfers) and Minister of Health and Welfare Canada (HWC) (administration of compliance provisions and payment of cash contributions under the CHA). (See separate paper on Administration of CHA).

Estimates of the EPF health transfers for 1985/86 total $11.2 billion; $6.7 billion in cash contributions and $4.6 billion in value in tax transfers.

DESCRIPTION

Present Arrangements

Nature of EPF

The EPF arrangements comprise transfers of (federal) fiscal resources (cash plus value of certain tax transfers) to provinces[1] to assist them to provide health and post-secondary education services.

Total Value of EPF Transfers

The total value of the EPF health and post-secondary transfers for each province is derived as follows:

Health:

a. the 1975/76 national average per capita federal contributions for hospital and medical care insurance ($144.25) escalated annually at the rate of growth of the economy (three year moving average GNP per capita)(=$401 per capita 1985/86);

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[1] In the context of this paper, the term provinces includes Yukon and Northwest Territories.

plus

b. $20 per capita for extended health services in 1977/78, escalated on same basis as in a., (=$43 per capita 1985/86);
(= total $444 per capita 1985/86)

multiplied by

c. the population of each province.

Post-secondary Education: (P.S.E.)

a. the 1975/76 national average per capita federal contribution for post-secondary education ($68.31) escalated annually as above, except for 1983/1984 and 1984/1985 when the PSE per capita growth was restricted to 6% and 5% respectively under the federal restraint program, (=$179 per capita 1985/86);

multiplied by

b. the population of each province.

Calculation of EPF Cash Contributions

Total entitlement for each province (as derived above) minus the value of tax transfers equals the cash contribution (or payment).

CHART 1

EPF HEALTH CONTRIBUTIONS, 1985-86
(dollars per capita)

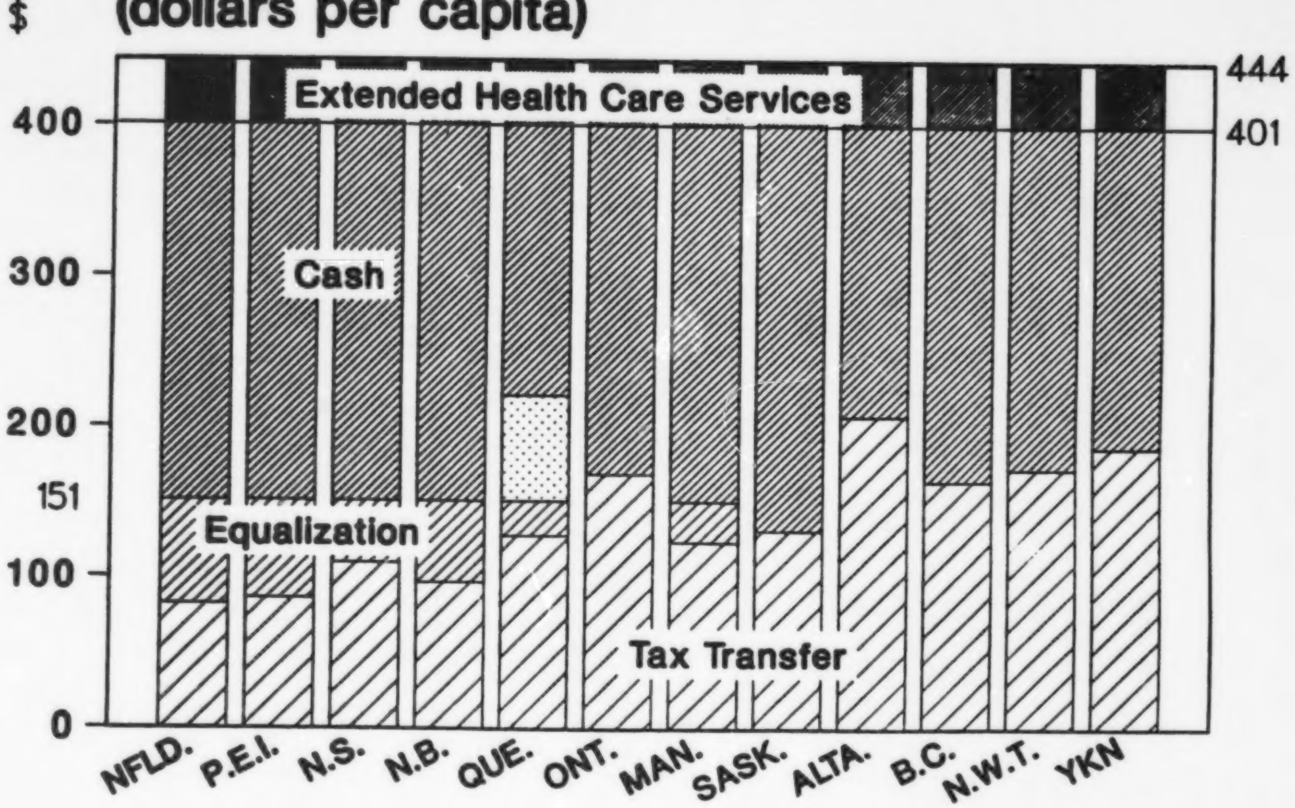

Chart 1 illustrates the division of the estimated EPF health per capita amount ($444) between cash and tax transfer in 1985/86. The table immediately following shows the estimated value of the EPF (health) transfers; - in tax and cash contributions, and in total for each province in 1985/86.

Value of EPF Health Transfers 1985/86 by Province (Estimated, September, 1985 at $444 per capita)

	Cash Contribution(1)	Value of Tax Transfers(2)	Total
	($000)	($000)	($000)
NFLD	170,282	87,092	257,374
P.E.I.	37,300	19,079	56,379
N.S.	258,194	132,054	390,248
N.B.	210,896	107,864	318,760
QUE	1,475,521	1,441,427	2,916,948
ONT	2,497,362	1,519,898	4,017,260
MAN	313,616	160,400	474,016
SASK	321,035	130,730	451,765
ALTA	561,656	478,870	1,040,526
B.C.	811,275	470,223	1,281,498
N.W.T.	13,633	8,928	22,561
YUKON	5,946	4,159	10,105
TOTAL	6,676,716	4,560,724	11,237,440

(1) Paid by the Minister of National Health and Welfare

(2) Includes the value of federal tax forgone plus equalization associated with the health portion of the EPF tax abatement. This "associated" equalization is included in the equalization payments made by the Minister of Finance to six recipient provinces (NFLD, PEI, NS, NB, QUE, and MAN).

Criteria and Penalties Attached to the Federal EPF Health Transfers

The Canada Health Act, assented to April 1984, replaced the Hospital and Diagnostic Service Act and the Medical Care Act. The CHA sets out the criteria and conditions regarding health insurance that are attached to the EPF health transfers and provides penalties if the criteria are not met. No criteria or penalties apply to the Extended Health Care Services portion of EPF.

EVOLUTION OF EPF

The Pre-EPF Period

The EPF arrangements began April 1, 1977. They replaced separate federal cost-sharing programs with the provinces for hospitalization (from 1957), medical care (from 1966) and post-secondary education (from 1967).

The Minister of National Health and Welfare made cash payments[1] under the Hospital Insurance and Diagnostic Services Act (HIDS) and the Medical Care Act. The Secretary of State made post-secondary cash payments and this transfer was authorized by the Federal-Provincial Fiscal Arrangements Act. The form of the post-secondary transfer also differed from the other two, i.e., an abatement of four equalized points of the personal income tax and one equalized point of corporation tax plus a cash adjustment payment.

The federal contributions were about half of total "eligible" costs, but the way the federal share was calculated differed for each of these three shared cost programs, i.e.:

> hospital insurance - (25% of national average provincial per capita cost plus 25% of a province's own per capita cost) x (population);
>
> medical care - (50% of national average provincial per capita cost) x (population);
>
> post-secondary education - the greater of 50% of institutional post-secondary education operating costs incurred in a province or $15 per capita in 1967 (the latter was escalated annually at a growth rate of eligible national post-secondary costs).

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[1] Quebec received part of its compensation in the form of tax transfer that had been effected through the Established Programs Financing (Interim Arrangements) Act, 1964.

Detailed conditions under signed agreements were attached to the hospital insurance program. Under medical care, the provinces had only to satisfy five criteria or principles (public administration, comprehensiveness, accessibility, portability of benefits and universality). No program condition was attached to the P.S.E. program. For all three, however, though advances were made based on estimates, final determination of amounts of the federal contributions required provincial submission of audited provincial and/or institutional statements of "costs eligible" for sharing.

Some provinces, objected in principle to the use of federal spending power in areas of provincial jurisdiction. By offering to finance half the cost, subject to certain conditions, the federal government, it was argued, impelled provinces to implement programs in social policy areas that, in some cases, they did not want or they would have delivered in a way different from that induced by federal "conditions".

Quebec took the lead in this regard, arguing for "contracting-out" arrangements to remove this imposition of federal priorities in provincial spending.

Because of these pressures the federal government in 1963 announced a willingness to withdraw from a number of "well established" social policy shared-cost programs, subject to a number of conditions. The Established Programs (Interim Arrangements) Act of 1964, subsequently provided the legal framework to implement this proposal. This Act authorized "contracting-out" on the basis of a transfer of (equalized) 20 percentage points[1] of the personal income tax. The value of these points would be augmented by cash adjustment to make the total compensation equal to what a province would have received in cash through the original shared-cost arrangements. In addition, a "contracting-out" province would have to adhere to all the contractual and conditional requirements of the programs. Finally, the determination of adjustment payments would have required the submission of detailed provincial cost records to the federal government. Quebec was the only province that took up this offer.

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[1]. 14 for hospital insurance, four for welfare programs, and one each for vocational training and national health grants respectively.

In 1966, the federal government advanced another proposal aimed at moving beyond the Interim Arrangements Act. This new offer[1] which proposed a tax transfer (+ cash adjustment) arrangement, also included an eventual detachment of transfer entitlements from provincial costs, as well as a substantial reduction of program conditions. General agreements were envisaged, covering portability of benefits and the maintenance of national standards in the health field. Quebec was interested, but the offer would have had to be accepted by all provinces before it would be fully developed and implemented.

The 1966 negotiations ended in, among other things, the introduction of the post-secondary fiscal transfer, involving federal sharing of P.S.E. operating costs and a compensation package based on a tax transfer and cash[2].

Somewhat similar proposals were advanced in the early 1970s, in one case based on a transfer of health and tobacco taxes, but the majority of provinces considered that the compensation offered (with future growth severed from program costs), did not warrant taking the risk of moving from the 50/50 sharing arrangement.

During the late sixties and early seventies, both levels of government became increasingly concerned with rapidly rising costs for the major programs they jointly financed. This was partly due to the use of matched funding arrangements which have a built-in bias for cost escalation in that provinces have to bear less than the full weight of new expenditure[1]. Provinces were urged to become more cost-efficient in the delivery of these services. They responded by noting that they were already doing a great deal, but that they were hampered by the rigidity of the cost-sharing conditions attached to hospital insurance and medical care programs. The detailed accounting and auditing requirements of these and the post-secondary programs were also costly and a source of ongoing irritation to both sides.

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[1] Hospital Insurance, Canada Assistance Plan and the continuing portion of National Health Grants.

[2] Four equalized percentage points of the personal tax and 1% of corporate taxable income.

Quebec, Ontario and Alberta, during this period, increased the pressures for federal withdrawal. At the same time, the federal government took a number of actions to stem the levering effect of rising costs on its contributions. In 1972, the federal government instituted a 15% cap on its transfers for post-secondary education.

Subsequently in 1975, in the run-up to the 1976 fiscal arrangements negotiations, the federal government announced a phased-in ceiling to its per capita contributions under Medicare - 13% in 1976/77, 10.5% in 1977/78 and 8.5% for subsequent years. At the same time, the federal government announced its intention to terminate the hospital insurance program in 1980, the earliest date permitted by legislation.

Given the dissatisfaction with cost-sharing at both levels of government, the stage was set for meaningful reform during the negotiations of 1976.

Negotiation of the EPF Arrangements in 1976

The proposed arrangements were tabled at the June 1976 Conference of First Ministers at which the then Prime Minister set out five principles to form the basis of future federal support for health and post-secondary education financing. These principles, and objectives drawn from them, are essentially those set out under OBJECTIVES at the beginning of this assessment.

It was proposed that the total value of per capita federal contributions in a base year 1975/76 (for the three programs in question) be escalated at the rate of growth of GNP per capita (three year moving average) to establish a national base per capita contribution for 1977/78 and for each following fiscal year. An additional $20 per capita was provided, beginning in 1977/78, to assist in financing Extended Health Care services. This was also to be escalated at the rate of growth of GNP per capita.

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[1] In fact, only the Post-Secondary Transfer was a full 50/50 sharing program in each province, i.e. if $1 were to be spent, the province got back 50¢. Medical Care had initially no cost increase incentive since payments were based on 50% of national average per capita eligible costs.

The federal contribution to each province would consist of cash and income tax room vacated to the provinces (12.5 personal income tax points and one point of corporate tax).[1]

During negotiations it was agreed that provinces that received less than average transfers per capita under cost-sharing would be levelled up to the national average over a three-year period. Provinces that received above average federal sharing in per capita terms, however, were to be levelled down to the national average per capita level over a five-year period.

In the final steps of negotiations the overall EPF transfer was increased by one additional point of personal income tax plus an equivalent amount in cash as compensation for the termination of the revenue guarantee payments; payments which were tied to claims for continuing provincial losses resulting from the federal tax reforms of 1972. The "compensation for termination" through EPF amounted to approximately 40% of what the original guarantee would have been worth to the provinces. The provinces, in accepting the EPF arrangement, also gave up claims to continued cost-sharing under the hospital insurance scheme, which was not due to expire until mid-1980.

Despite the risk entailed in a GNP driven formula, (unrelated to growing costs), provinces accepted the new arrangements in light of the increased flexibility which would allow them to rationalize their delivery systems towards lower cost alternatives, particularly in the health area. From the federal point of view, tying transfers to the rate of growth in the economy provided the predictability sought over its payouts. (However, accountability to Parliament for block-funded spending eventually became a

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1. The then existing tax transfers related to post-secondary education were to be subsumed in these totals.

concern.) Finally, both levels of government were relieved of the burdensome administrative requirements characteristic of shared-cost schemes.

The detailed conditions attached to the hospital insurance program were to have been superseded by the extension of the five principles of the medical care program to the whole health insurance field through new federal legislation. Provision of ongoing federal/provincial discussions and development of policies of national significance in health and post-secondary fields were envisaged.

Experience with EPF 1977/78 through 1981/82

Basically, the new EPF arrangements attained the objectives set by the federal government in 1976; the exception was the lack of any provision for ongoing discussion of policy matters, particularly as regards post-secondary education.

However, a new Health Act was not enacted. Consequently, though authority for the calculation of EPF transfers (and for post-secondary and Extended Health Care payments) was provided in the Fiscal Arrangements and Established Programs Financing Act, 1977, the authority for making payments under the hospital insurance and medical care programs remained in the HIDS and Medical Care Acts. Therefore, the original program criteria continued in force with the Minister of HWC retaining authority to withhold the "entire" payments where federal conditions were not satisfied.

In general provinces were satisfied with the EPF arrangements. Similarly, the federal government, "...though concerned about accountability to Parliament for block-funded spending...obtained more certainty in budgeting for its contributions to the areas in question"[1]. Nevertheless, because during these five years the federal government felt impelled to impose restraints on its own spending, the EPF transfers (growing with an inflated GNP) became a target for increasing concern. As part of its restraint exercise, the federal government in 1978 proposed to shave two percentage points off the GNP escalator, but did not proceed.

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(1) Report of the Parliamentary Task Force on Federal/Provincial Fiscal Arrangements, August 1981, page 71.

Concerns also arose in the public mind, among interest groups, and consequently, among federal politicians, about the maintenance of adequate programs in the health insurance and post-secondary areas.

Some federal and provincial politicians and "interest groups" alleged that provinces were underfunding health care and post-secondary education, as implied by a rising federal share of financing for these functions. In the health care area, in particular, Justice Hall examined the arguments that provinces were diverting federal cash transfers for health to other uses and exonerated the provinces of any wrong-doing. In fact by 1979 or 1980 the more rapid growth of EPF transfers over provincial spending in both fields had been reversed.

These issues and others related to the whole field of fiscal arrangements were studied and reported on with recommendations by a Parliamentary Committee in 1981. Some, but not all of the recommendations and concerns of this Committee were incorporated into the 1982/83 fiscal arrangements and the new Canada Health Act.

Changes to EPF Arrangements Effective 1982/83 and Other Developments

In 1982, the federal government recovered the cash equivalent of EPF revenue guarantee compensation, yielding federal savings estimated to be $6 billion over the five years to 1986/87.

In 1984, the EPF transfer was formally split in the legislation into separate health and post-secondary education components. Since the cash transfer was designated between the two functions from the beginning of EPF, the change formally enshrined a division of the total EPF package.

The Canada Health Act was passed and became effective April 1984. This Act set out criteria and conditions to be met by provincial health insurance plans to qualify for EPF cash contributions. Penalties for non-compliance are also provided.

Six and five per cent restraints were applied to the per capita contributions for post-secondary education, resulting in federal savings of $104 million in 1983/84 and $247 million in 1984/85. The permanent lowering of the base per capita contributions results in ongoing annual savings to the federal government.

EVALUATIONS

No formal evaluation of EPF has been done. However, the report of the Parliamentary Task Force on Fiscal Federalism in Canada (Breau Report) was an examination of the EPF arrangements.

OBSERVATIONS

Financial Commitment to Maintenance of Standards

The maintenance of national standards or principles requires that sufficient resources be committed to the health care system.

However, any examination of the adequacy of funding levels is beset with difficult measurement problems and a lack of clarity in the five basic principles or standards of the Canada Health Act. Under these circumstances, judgements as to whether the system is overfunded or underfunded become largely subjective.

This is reflected in the conclusions of two recent assessments of the "underfunding" allegation. The CMA in its examination of the matter concluded that "the evidence is contradictory and inconclusive" and on that basis, it would not support "the contention that there is underfunding generally in Canada". The Parliamentary Task Force on Federal-Provincial Fiscal Arrangements on the basis of its examination concluded that "the evidence is not sufficient to demonstrate that the system is underfunded".

Under EPF, the federal government committed itself to paying a substantial share of program costs. At the present time, the portion of EPF assigned to health is equal to about 40% of all provinces' health spending, with the rate for individual provinces varying within plus or minus 7% of this.

Over the recent past, federal contributions have grown more slowly than provincial spending because of a number of pressures within the system. Provinces have indicated to the Study Team that for the immediate future, they are looking at expenditure increases of 4% or 5% above the inflation rate owing to the costs of serving an aging population, steadily increasing usage rates and the growing cost of new technology.

Provinces have complained of a two sided strain on their finances. On the one side, they have had to adjust to the federal withdrawal of almost $6 billion in revenue guarantee compensation over the five years to 1986/87. At the same time, the Canada Health Act has placed new demands on them and restricted their revenue raising flexibility. For example, the portability provisions requiring the payment of host province rates will add to costs in some provinces. References to health care practitioners in the legislation is said to have created pressure for bringing additional services under the insurance plans. Differential user charge schemes to encourage movement away from expensive institutional treatment to low-cost community-based alternatives are not allowed under the Act.

Greater Equality in Per Capita Payments

EPF has resulted in equal per capita entitlements among provinces.

Through levelling provisions over the first five years of EPF the per capita entitlements were gradually made equal across nine provinces. The exception was Alberta which owing to the working of the formula received a bonus per capita amount from its above average income tax growth. The so called "fiscal dividend" to Alberta was removed in 1982, thus creating full equality in the per capita transfer amounts for all provinces.

Stability and Permanence of Funding

By linking its transfers to recent growth in the economy rather than provincial spending, the federal government has gained a measure of predictability over its transfers. EPF has not been a stable source of financing for provinces.

Within two years of the introduction of EPF, the federal government attempted unsuccessfully to reduce the transfer escalator. Actual cuts came in fiscal 1982/83 with the removal of the revenue guarantee component of EPF, followed in 1984 by six and five program restraints on the federally designated EPF support for post-secondary education in 1983/84 and 1984/85.

Flexibility

From the beginning of EPF the federal government has followed the practice of designating EPF support between health and post-secondary education. This division of EPF was originally made to permit cash payments to flow through the Secretary of State and the Minister of Health and Welfare, Canada.

The split has regularly been used to determine federal "shares" of spending, a notion contrary to the detachment of federal transfers from provincial spending under EPF.

While provinces may use federal funds as they see fit both within and between the two functions, their spending behaviour has often met with federal charges such as provincial underfunding, diverting EPF monies to highways, and rising federal "shares".

There is concern that the Canada Health Act will limit the flexibility of provinces to pursue ways of improving efficiencies in the health care system.

Forum for Joint Policy Discussions

The Federal Provincial Advisory Committee structure has continued but it has dealt mainly with program and technical issues. Policy issues were rarely addressed and deputy ministers and ministers met only sporadically. There have been a few notable exceptions, (e.g., Canadian blood policy and medical manpower).

During the period of development and passage of the Canada Health Act, there was no federal/provincial discussion of the policy issues involved.

PROVINCIAL VIEWS ON EPF

The provinces and territories are all strongly in favour of the block funding under EPF in accordance with the principles enunciated in 1976 by the then Prime Minister. However, they resent the Canada Health Act, and past EPF cuts.

OPTIONS

The study team recommends to the Task Force that the government, in collaboration with the provinces, consider changing its role from a focus on provincial illness-treatment programs to one that emphasizes personal responsibility for one's health through healthier lifestyles, illness and disease prevention, and so on. This would involve, inter alia, partial federal disengagement from financial or direct substantive influence on provincial illness-treatment plans, leaving the provinces, to the fullest extent possible, responsible for raising revenues for and cost control of their health insurance systems. At the same time, a monitoring mechanism would need to be put in place, under agreements with the provinces, which would ensure the maintenance of agreed basic national standards of service across the country.

The study team envisages such a regime being developed, in close collaboration with the provinces, over a five-year period.

HEALTH INSURANCE -
(ADMINISTRATION OF CANADA HEALTH ACT 1984)
(Health and Welfare Canada)

OBJECTIVES

Objectives of the Act;

Section 3 of the Act says;

"PURPOSE

The purpose of this Act is to establish criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law."

Note The ".... Act of 1977..." means the Federal-Provincial Fiscal Arrangements and Federal Post-Secondary and Health Contributions Act, 1977.

Other (Administrative) Objectives

Make Established Program Financing (EPF) "cash contribution" payments to provinces.

Enable the Minister to judge whether the five criteria and other conditions in the Act are being satisfied by each province, and if not what penalties should be imposed.

Enable the Minister to be accountable to Parliament. (Annual report required by section 23 of the Canada Health Act (CHA) regarding EPF health cash contribution paid to the provinces, and the extent to which provincial health insurance plans satisfy the five criteria, etc.)

Facilitate policy analysis regarding health insurance/health care and the federal role(s) in Canada's health systems.

BENEFICIARIES

Indirectly, through provinces and territories, virtually all residents of the country.

Federal estimates of health insurance and extended health care services contributions for each province in 1985/86 are set out below.

1985/86 Estimates of EPF (Health) Contributions in Relation to Estimated Provincial Health Expenditure

Prov.	Cash Contrib. ($Million) (1)	Tax Abatement & Equal. ($Million) (2)	Total (1) & (2) ($Million) (3)	Total Provincial Health Exp. ($Million) (4)	% Percentage (3)of(4) (5)
NFLD	170.3	87.1	257.4	572.8	44.9
PEI	37.3	19.1	56.4	120.5	46.8
NS	258.2	132.1	390.2	864.2	45.2
NB	211.0	107.9	318.8	697.4	45.7
QUE	1,475.5	1,441.4	2,916.9	7,354.2	39.7
ONT	2,497.4	1,519.9	4,017.3	9,235.6	43.5
MAN	313.6	160.4	474.0	1,186.6	39.9
SASK	321.0	130.7	451.8	1,103.0	41.0
ALTA	561.7	478.9	1,040.5	3,146.5	33.1
BC	811.3	470.2	1,281.5	3,213.4	39.9
NWT	13.6	8.9	22.6	88.5	25.5
YUKON	5.9	4.1	10.1	28.8	35.1
TOTAL	6,676.7*	4,560.7*	11,237.4*	27,661.4**	40.6

* Source: Department of Finance for EPF data
** Source: Department of Health and Welfare Canada (HWC) for Provincial Health Expenditures

RESOURCES

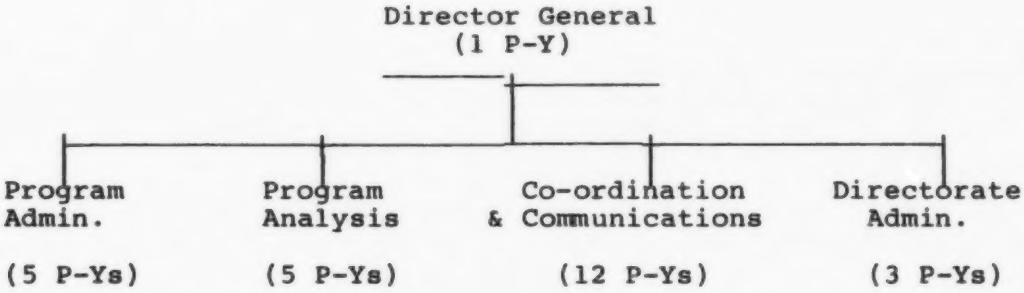
The Health Insurance Directorate has a permanent establishment of 16 person-years. However, the tasks being performed have impelled the department to lend temporarily 10 additional employees to the Directorate. Department administration supports an establishment of 26 person-years, but approval has not yet been received for the extra 10. It may have to be sought from Cabinet.

Estimates of Person-Years and Expenditure, 1985/86

	Present Approved Establishment	**Requested Additional**	**Total**
Salaries & Wages	$768,000	$370,000	$1,138,000
Operation & Maintenance	170,000	210,000	380,000
TOTAL	$938,000	$580,000	$1,518,000
Cash Contribution Payments to Provinces			$6.7 Billion
Person-years	16	10	26

Organization Chart

Health Insurance Directorate


Director General
(1 P-Y)
Program Admin.
(5 P-Ys)
Program Analysis
(5 P-Ys)
Co-ordination & Communications
(12 P-Ys)
Directorate Admin.
(3 P-Ys)

DESCRIPTION

Introduction

The CHA, in effect, replaced the Hospital Insurance and Diagnostic Services Act and the Medical Care Act. The Act sets out and elaborates definitions of the five criteria to be satisfied for a province's health insurance plan to qualify for EPF (health) contributions. Certain other conditions of payment are also established, and deductions for failure to meet the criteria and/or other conditions are provided for. An elaborate procedure for deciding and effecting deductions from cash contributions is prescribed. Finally, consultation with the provinces is required on virtually all aspects of the administration of the Act.

Outline of Provisions of CHA

In brief, the CHA says that:

To qualify for a cash contribution a province's health insurance program must satisfy five national program criteria:

public administration, i.e. through a public authority on a non-profit basis;

comprehensive coverage of wide range of hospital and medical services;

universality, i.e. insured coverage of all residents under uniform terms and conditions;

portability, i.e. provides insured coverage (to residents) when temporarily absent or moving from province to province; and

accessibility, i.e. provides reasonable access to services ... without barriers, financial or otherwise. (In addition, provinces are to provide reasonable compensation to providers of services.)

Actual cash payment of a cash contribution is subject to the following conditions:

the provision of such information as may be required by the Minister of Health and Welfare Canada (through regulations) to carry out the provisions of the CHA;

the recognition of federal contributions in (provincial) public documents related to health insurance and extended health care programs; and where extra billing/user charges exist, cash payments will not be made in respect of those insured services that have been subject to such extra billing (by practitioners) or user charges (by institutions).

Ongoing Requirements in Current and Future CHA Administration

To define the boundaries between insured services (where extra billing draws penalties) and non-insured services, and also to clarify boundaries between services in hospitals (i.e. insured) and those in extended care facilities (i.e. non-insured). There is a similar problem regarding the health services provided in institutions under CAP* sharing. In all these cases there are interprovincial differences.

To ensure that "accountability" judgements can be made and reports submitted to Parliament on the extent to which provincial health insurance plans satisfy the criteria and conditions of payment established in the CHA.

To monitor health insurance plans and certain other provincial activities to determine whether criteria and other conditions are being satisfied etc. Where they are not met, to determine the value of non-compliance.

To calculate deductions from cash contribution where any one of the criteria is not met, or extra billing or user charges are imposed, or other "conditions of payment" are not satisfied.

To obtain (from Information Systems Directorate (HWC), Statistics Canada, and as required from provinces) the information needed for such policy analysis as may arise in the ongoing administration of the CHA, or regarding future federal policies in the health insurance and other health service areas.

To interact with those in the public sphere who have a special concern or interest in health insurance matters.

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* Canada Assistance Plan, - 50/50 sharing of provincial expenditure.

Outline of Tasks Assigned to Each Division in Health Insurance Directorate

Program Analysis Division (5 P-Ys)

Interpretating provisions of the Act: basically what services are to be insured in provincial plans and what constitutes non-compliance;

Identifying problems of interpretation and compliance and developing possible solutions; and

Answering policy questions for others in the Directorate and for the Minister.

The biggest questions to be settled center around portability of medical benefits. Other interpretation or compliance questions include those associated with universality, comprehensiveness and accessibility.

Program Administration Division (5 P-Ys)

Examining data and information on provincial health insurance operations and deciding whether criteria and conditions are being met. The data are normally supplied by Co-ordination and Communications (see below).

Authorizing payments of "Cash Contributions".

Most decisions regarding compliance are of a definite no/yes or black/white nature. However, where grey areas are encountered, additional facts are sought through informal consultations with provinces. If necessary interpretations are sought from Program Analysis Division.

If non-compliance is found, the matter is moved to the Minister for consultation with his counterpart(s). The next step, if there is no resolution, is development of a Cabinet document regarding the breach and possible corrections.

Coordination and Communications Division (12 P-Ys)

Gathering information (descriptive and hard data) on provincial plans including up to date copies of provincial health insurance legislation, administrative guidelines, regulations, plan brochures, etc. (4 P-Ys).

Coordinating replies to the Minister's correspondence on health insurance matters; (3000-4000 pieces a year, of which 75% are routine, perhaps 20% pose moderately difficult questions and 5% are very difficult to respond to) (5 P-Ys).

Responding to questions and requests from groups and others outside government, e.g. interaction with hospital and medical organizations, preparing material for speeches by the Minister, responding to briefs, etc. (3 P-Ys).

Current Situation Regarding Acquisition and Use of "Required" Information

The Minister of National Health and Welfare has adopted a (intergovernmental) cooperative approach to the administration of the CHA. He has also indicated that he wishes to rely on information provided by his provincial counterparts in judging whether, or the extent to which, the five program criteria and other conditions of payment are being met by each province. He has also said that he will not set up new requirements but will use data now being collected, e.g. by Information Systems Directorate and Statistics Canada.

The Directorate has been following the cooperative approach to date in seeking data about extra billing and user charges. Similarly, it has asked provinces to forward "accountability statements" (based on guidelines provided by the Directorate) for use in drafting the Minister's first report to Parliament on the extent to which the criteria and conditions in the CHA have been satisfied. A few of the provinces have, so far, provided little or no extra billing/user charge information and the "accountability statements" received vary in content from province to province. Deductions, in the cases of those not providing extra billing/user charge information were initiated on the basis of federal estimates.

The Act is, however, grounded in a policing and punitive philosophy. Consequently, it is proving difficult for the Directorate to avoid a detailed and intensive approach with the provinces to obtain the necessary data which will ensure that the Minister will be able to be "accountable" to Parliament under the Act. Indeed it may be impossible in the longer run to retain a cooperative approach without changes in the Act.

An additional concern stems from the Auditor General's recent report. It was noted in that report, that in 1982 monitoring of compliance by provinces with the conditions in the Federal-Provincial Fiscal Arrangements Act was limited. The Auditor General then briefly traced the changes flowing from the passing of the CHA and the change of government in 1984, and indicated an intention to follow-up in 1986 after the first report to Parliament (by the Minister of HWC) is tabled.

Extra Billing and User Charge Deductions

Under the C.H.A. ($000)

Province	**1985/86 Monthly Total ($000's)**	**To Date (Sept. 85) Total Deductions ($000's)**
N.B.	306	4,590
QUE.	877	13,155
ONT.	4,444	66,660
MAN.	0	1,270
SASK.	0	2,107
ALTA.	988	15,864
B.C.	2,695	38,967
TOTAL	9,310	142,613

Note Sask. and Manitoba are now deemed to be in compliance with the Act and their deductions have been refunded.

PROVINCIAL VIEWS

The provinces opposed the passing of the CHA in principle and in detail. They saw it as a step back both from the flexibility and the non-interference philosophy of the original EPF block-funding for health and post-secondary education. The provinces continue to resent the existence and the administrative requirements of the Act, even though the Minister has adopted, to the extent possible, a cooperative and accommodating approach.

EVALUATION

No evaluation of this program has been done. (See, however, Auditor General's comments above about a review of federal monitoring of compliance with the CHA.)

OBSERVATIONS

The CHA led to the implementation activities undertaken by the Health Insurance Directorate over the last year.

Uncertainties are encountered in trying to judge the Directorate's future role and costs. An initial reaction is to question why 26 person-years should be required to carry out a cooperative approach to policing compliance with the CHA. However, a cursory examination of the activities that flow from the provisions of the Act suggests, at least for the short run, a substantial ongoing work load; a work load that will involve good judgement, the ability to relate program details to general criteria, and skillful liaison activities in a fairly hostile intergovernmental environment.

Our evaluation of the CHA has been dovetailed with the views of the Study Team on the Federal Role in Health Care in Canada and on the EPF health transfer.

The Health Insurance Directorate uses data being captured by Information Systems Directorate and by Statistics Canada. Therefore, what is decided in the evaluation of the Health Statistics and Data Programs could have important effects on the administration of the CHA.

As noted above, it seems clear that there are very difficult administrative and federal/provincial relations problems inherent in the structure of the CHA. However, these will probably have to be accepted or at least tolerated in the short run. Perhaps the Minister and his officials will be able to do what is essential to discharge his responsibilities in the short run through flexible approaches that involve liberal interpretations of the provisions in the Act. However, this might not be possible indefinitely because the Act requires accountability to Parliament.

OPTIONS

The study team recommends to the Task Force that the government in collaboration with the provinces, consider changing its role from a focus on provincial illness-treatment programs to one that emphasizes personal responsibility for one's health through healthier life-styles, illness and disease prevention, and so on. This would involve, inter alia, partial federal disengagement from financial or direct substantive influence on provincial illness-treatment plans, leaving the provinces, to the fullest extent possible, responsible for raising revenue for and cost control of their health insurance systems. At the same time, a monitoring mechanism would need to be put in place, under agreements with the provinces, which would ensure the maintenance of agreed basic national standards of service across the country.

The study team envisages such a regime being developed, in close collaboration with the provinces, over a five-year period.

FEDERAL ROLE IN HEALTH CARE IN CANADA

Introduction

The question of the federal jurisdiction and role in health care in Canada is a central issue in any review of federal health programs. The assessment framework for reviewing federal programs must be based on and be tested against a clear statement of the federal government role. This paper sets out the federal jurisdiction in health, the federal involvement in provincial programs of national interest and the Study Team's view as to the appropriate role for Health and Welfare Canada (HWC) in the future.

An underlying assumption to this discussion is that there is an overriding national interest in protecting the health of Canadians and in maintaining the health care delivery system in accordance with established principles.

In the discharge of its role the federal government must develop mechanisms for working in close cooperation with provinces where considerations of national interest might lead the federal government to infringe on areas of provincial jurisdiction.

Federal Jurisdiction

The British North America Act granted primary jurisdiction over health services to provincial governments. Under section 92 each provincial legislature "may exclusively make laws in relation to the establishment, maintenance and management of hospitals, asylums, charities and (related) institutions in and for the province, other than marine hospitals". It also gave provinces jurisdiction over "generally all matters of a merely local or private nature in the province".

Section 91 gives the federal government responsibility for:

a. "quarantine and the establishment and maintenance of marine hospitals,
b. nationalization and aliens,
c. the census and statistics".

It also enables the federal government to provide health services for the military 91(4), Indians 91(24), RCMP 91(27), inmates of penitentiaries 91(28) and the responsibility for the quality of food, drugs, and environmental hazards (91(2) Regulation Trade and Commerce).

The power to "make laws for the peace, order and good government of Canada" and its spending powers provide the legal basis for federal involvement in provincial social programs.

Federal Involvement in Provincial Programs of National Interest

Commencing in 1945, the federal government adopted policies based on the assumption of "a broad federal responsibility, in cooperation with provincial governments, "for establishing the general conditions and framework for high employment and income policies and for the support of national minimum standards of social services". The policies also assumed "that provincial governments should be in a financial position to discharge their responsibilities adequately"[1].

Based on this policy and the federal spending power in the BNA Act, the federal government over the next 20 years, advanced proposals and implemented programs designed to induce provinces to put in place a comprehensive health insurance program for Canada based on national minimum standards.

During the period up to 1967 (and the introduction of the Medical Care Act) there was, with the exception of Quebec, general acceptance by the provinces of a leadership role in the health care field by the federal government. There seemed to be few serious differences on the basic objectives. However, in the 10-year period from 1967 to 1977 there was growing provincial disenchantment and concern with the federal role in influencing provincial priorities and restricting provincial flexibility in responding to the health needs of their populations. This, combined with federal concern about its ability to control the rate of growth of contributions under shared cost programs and a perception that health programs had reached a level of maturity, led to Established Program Financing (EPF) "block funding" in 1977. Provincial government acceptance of federal leadership with respect to health programs further diminished with the implementation of EPF.

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[1]. Dominion Provincial Conference, 1945, Proceedings, p.5.

The growing conflict after 20 years of substantial agreement on basic objectives may, as suggested by the Parliamentary Task Force[1], have had more to do with the slow growth in the economy than major disagreements about objectives for health programs.

However, it also reflects the conflict that is inherent in a federal system, particularly when the federal government and the Parliament of Canada decide that, for instance, health services at some national level should be made available across the country. The very purpose of the shared-costs arrangement, in such a situation, is to influence provincial budgets based on federal and Parliamentary priorities. Conflict cannot be avoided, and will continue so long as the federal government insists on all provincial programs meeting defined criteria or conditions.

The Parliamentary Task Force concluded that "there is an over-riding national interest in the operation of health plans and in the effectiveness of health care delivery". They recommended that "the proper role for the federal government is the formulation, monitoring and enforcement of conditions on its financial support of provincial programs".

This recommendation, the comments and recommendations of the Honourable Emmett Hall in his 1980 report[2], the federal perception and concerns about possible erosion of the system and perceived popular support all led the federal government to issue a position paper entitled "Preserving Universal Medicare" in July 1983. Subsequently, it introduced the Canada Health Act. This was passed with the support of all federal political parties in April, 1984.

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[1] "Fiscal Federalism in Canada", Report of the Parliamentary Task Force on Federal-Provincial Fiscal Arrangements, August 1981.

[2] Canada's National-Provincial Health Program for the 1980's - "A Commitment for Renewal", The Hon. Emmett M. Hall, CC, OC, Special Commissioner, August, 1980.

There was strong provincial opposition to that action. It was seen as an intrusion into areas of provincial jurisdiction and not required in order to maintain an effective program of health care services for Canadians. As a result, even though with the change in government in 1984 there have been strong attempts to improve relations, there still exist feelings of antipathy in this area.

In this atmosphere it will be very difficult for the two parties to jointly define the federal role for the future, a role consistent with the federal government's responsibility for ensuring the national interest is met with respect to health care.

Present Role

The Department of National Health and Welfare Act, passed in 1945, sets out the role that the federal department was assigned. (See attachment 1)

Regulatory - The federal health department has a regulatory role in respect of quality and safety of foods, drugs and certain environmental hazards. It also certifies medical exams required for the licensing of pilots, administers quarantine regulations and inspects conveyances and international travellers.

International relations - Health and Welfare Canada is responsible for Canada's relations with other countries and the UN with respect to health matters. Provincial cooperation is required as most matters are related to those in the provincial jurisdiction.

Services - Provided by HWC

deliver services to Indians and Inuit except where services are, by agreement, delivered by the provinces;

pay for health services provided to persons from other countries that do not yet have landed immigrant status; (Some provinces are dubious about picking up these costs.).

provide prosthetic services in four locations in Canada;

assemble and disseminate information on health services to and on the health status of Canadians; (also provided by Statistics Canada)

operate a central laboratory for disease control;

develop and implement, in cooperation with the provinces and territories, health promotion programs;

provide occupational health services for federal public service employees;

plan for the provision of health services under emergency conditions, provide advice and consultation to the provinces and arrange training for provincial staff; and

fund health care research.

Funding - In 1985/86 Health and Welfare Canada estimates that the federal government funds approximately 32% of all spending on health in Canada and about 40% of spending on health by governments.1

Federal funding for health services delivered by the provinces is provided under EPF. The Canada Health Act places responsibility on the federal government for monitoring provincial health plans to determine whether program criteria are met. This and the funding it provides gives it a strong role in ensuring a national program.

Leadership and Coordination - By virtue of its position as a national government and given the fact that it is difficult for individuals or organizations to relate to 10

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1. Note that this is based on the inclusion, in the federal portion, of revenue gained from tax points that were transferred to the provinces under EPF.

provincial and two territorial governments, the federal government often assumes a leadership role.

As well, in order to carry out its own mandate, the federal government may occasionally have to provide leadership. It is sometimes necessary to provide a focus for the coordination of the provincial activities.

The federal government has a number of instruments, in addition to funding, that it uses in exercising this leadership and coordination role. These are:

Consultation - with provinces and national organizations.

Facilitation - information exchange, funding research and development, hosting conferences, convening study or working groups, etc.

Information - collection, analysis and dissemination.

Communication - ensuring that important developments, new information or research results, etc., are communicated to a network.

Advocacy - identifying issues and pressing for the development of a response or action plan.

Observations

Federal Role - There is general provincial support for the federal government to:

improve the regulatory programs particularly with respect to testing for and identifying environmental hazards, testing medical devices and ensuring the quality and efficacy of drugs;

undertake surveys of the health status of Canadians that would provide information on the results of health care programs and would point the way to improvements required;

fund, jointly with the provinces, demonstration or experimental projects designed to develop systems for health care delivery that are more cost efficient in the long run;

continue to operate a central laboratory for disease control and for reference;

fund health care research; and

plan for the provision of health services in the event of national emergencies.

Quebec generally supports federal administration of regulatory programs but not necessarily the other points.

Consultation and Collaboration. With respect to mechanisms for federal/provincial collaboration and consultation, the provinces, with the exception of Quebec, indicated support for the present system of federal/provincial staff advisory committees. Many felt that these could be strengthened by developing a system of regular meetings of Deputy Ministers and Ministers to which the groups could report with recommendations.

Health Promotion. In our consultations we found that all provinces, except Quebec, agreed there is a role for the federal government, providing activities are well coordinated with the provinces. There have been problems in the past but there seems to be general acceptance of the current thrust. The less wealthy provinces need the federal programs in order to provide a base level of health promotion services because of the expense of preparing major media presentations and preparing print materials. A number commented on the confusion between health promotion, fitness and PARTICIPaction activities sponsored by the federal government.

Health Information. By virtue of the BNA Act, the Statistics Act and the Canada Health Act there is a clear role for the federal government. However, it is generally agreed that there needs to be a full review of the information to be collected and disseminated.

Direct Services to Individuals. The federal government has responsibility under the BNA Act for Indians, Inuit, veterans, the military, RCMP and federal penitentiary inmates. They have for some time been negotiating the transfer to the provinces of provision of services to veterans. Provinces provide insured services to Indians and, in those with small numbers of Indians, often provide the same range of services as are provided to other residents. In provinces with large populations of Indians, there is concern about the level of services to Indians and about the potential cost of taking responsibility for service delivery. Generally, provinces feel that they could deliver the services more efficiently and effectively but would want the agreement of the Indians to any transfer as well as appropriate compensation. In the Yukon and NWT, the federal government provides health care services to residents (native and non-native) on a temporary and reimbursable basis until territorial governments are in a better position to take over the responsibility.

Communication/Consultation. The smaller and less affluent provinces feel that the federal role in facilitating exchange of advice and information is important. For the others, this is much less important.

Funding. We found the officials in all provinces support EPF but it is clear that all are very concerned about changes that have been made to the original arrangements by the federal government.
Cost escalation is a concern for all provinces and there is no evidence that any jurisdiction will be able to hold cost increases at or below the inflation rates in the forseeable future. Provinces feel that the impacts of aging, technology, medical manpower and usage rates are and will continue to exert substantial upward pressures on costs. In this situation, an EPF escalator based on GNP is likely to result in federal payments growing at a rate slower than health costs.

Reductions in federal funding under EPF will, for the provinces, result in one or more of the following:

transfer of health costs to individuals (within the limits of the Canada Health Act);

increased taxes at provincial levels;

reduction in services and/or quality of health care services;

reduction in provincial programs in areas other than health care.

However, such reductions could also result in improved effectiveness and/or efficiency of health programs.

A number of provinces have suggested the need for greater federal participation in funding of demonstration or experimental projects designed to point the way to cost efficient systems for health care delivery.

Canada Health Act - The Canada Health Act ensures a continuing federal role in the monitoring and enforcement of national standards for health care programs in Canada. Provinces resent the penalties in the Act as well as the limits they feel are placed on their ability to respond to cost pressures and rapidly changing delivery systems.

As well, there are difficult administrative, technical and political issues which need to be resolved by continuing federal/provincial negotiations.

ASSESSMENT

It is the view of the study team that the way in which the federal government discharges its responsibilities in the health care area depends on the level of its involvement. There are three distinct levels as set out below.

Federal Jurisdiction

Federal jurisdiction is clearly established in the following areas of health:

regulatory programs;

international relations;

provision of services to federal clientele either directly or indirectly; and

collecting and disseminating health statistics and health data.

In carrying out its responsibilities in this area, the federal government needs to consult with provinces, seek advice, and in some cases, obtain provincial agreement (e.g., international agreements relating to matters within provincial jurisdiction).

Shared Federal/Provincial Involvement

The following health responsibilities are matters of shared involvement or jurisdiction:

health surveillance;
funding of research;
health promotion; and
planning for national emergencies.

In this area, federal leadership and coordination using the instruments now available is generally accepted. However, there must be meaningful provincial involvement in planning and policy development. There should also be continuing discussion with the provinces about the way in which the federal government uses those instruments with a view to getting agreement on approaches.

The Study Team felt that the promotion of more positive individual and societal attitudes towards health must be a major goal for the health care system. Effective cooperation in developing and implementing programs to accomplish this goal is dependent on ending, or at least reducing conflict with respect to funding and the maintenance of health delivery programs in accordance with established principles.

Areas of Provincial Jurisdiction where there is a National Interest

There is an overriding national interest in maintaining health care delivery programs in accordance with established standards. These established standards are those in the Canada Health Act.

In carrying out its responsibilities in this area the federal government has only its spending powers to enable it to ensure that national standards are maintained. Monitoring, consultation, advocacy and, as a last resort, penalties are the instruments available to the federal government.

A Need to Reduce Conflict in Areas of Provincial Jurisdiction

The Study Team believes that it is in this third area that the federal government must develop a strategy to end conflict and move cooperatively to resolve major problems of control of cost escalation in health services. Costs are now growing at rates faster than the growth of the economy. The reasons for the cost escalation are many and varied as set out in the section on issues. This is an area of provincial jurisdiction. However, the federal government's responsibility for the health of the economy and for ensuring health services continue to meet national standards means that it must be involved.

Suggested Strategy

The study team has suggested a strategy for consideration by the government to reduce conflict in the area of provincial jurisdiction where there is a national interest. As mentioned earlier there is no basic disagreement on the other areas (federal jurisdiction and shared involvement). However, effective joint action in these two areas depends on reducing the conflict in the third. Details of the strategy are set out in the section entitled Federal/Provincial Relationship.

DEPARTMENT OF NATIONAL HEALTH AND WELFARE ACT
Section 5
Duties of Minister

The duties, powers and functions of the Minister extend to and include all matters relating to the promotion or preservation of the health, social security and social welfare of the people of Canada over which the Parliament of Canada has jurisdiction, and without restricting the generality of the foregoing, particularly the following matters:

a. the administration of such Acts of the Parliament of Canada and of orders or regulations of the Government of Canada as are not by law assigned to any other department of the Government of Canada or any minister thereof relating in any way to the health, social security and welfare of the people of Canada;
b. investigation and research into public health and welfare;
c. the inspection and medical care of immigrants and seamen, and the administration of marine hospitals, and such other hospitals of the Government of Canada as may be committed to its administration by order of the Governor in Council;
d. the supervision, as regards the public health, of railways, boats, ships, aircraft and all other methods of transportation, and their ancillary services;
e. the promotion and conservation of the health of the civil servants and other government employees;
f. the enforcement of any rules or regulations made by the International Joint Commission, promulgated pursuant to the treaty between the United States of America and His Majesty, King Edward VII, relating to boundary waters and questions arising between the United States and Canada, so far as they relate to public health;
g. subject to the Statistics Act, the collection, publication and distribution of information relating to the public health, improved sanitation and social and industrial conditions affecting the health and lives of the people; and
h. cooperation with provincial authorities with a view to the coordination of efforts made or proposed for preserving and improving the public health and providing for the social security and welfare of the people of Canada. R.S., c.74, s.5; 1962-63, c.16, s.1

OVERVIEWS AND PROGRAM ASSESSMENTS

HEALTH PROTECTION
Overview

Programs

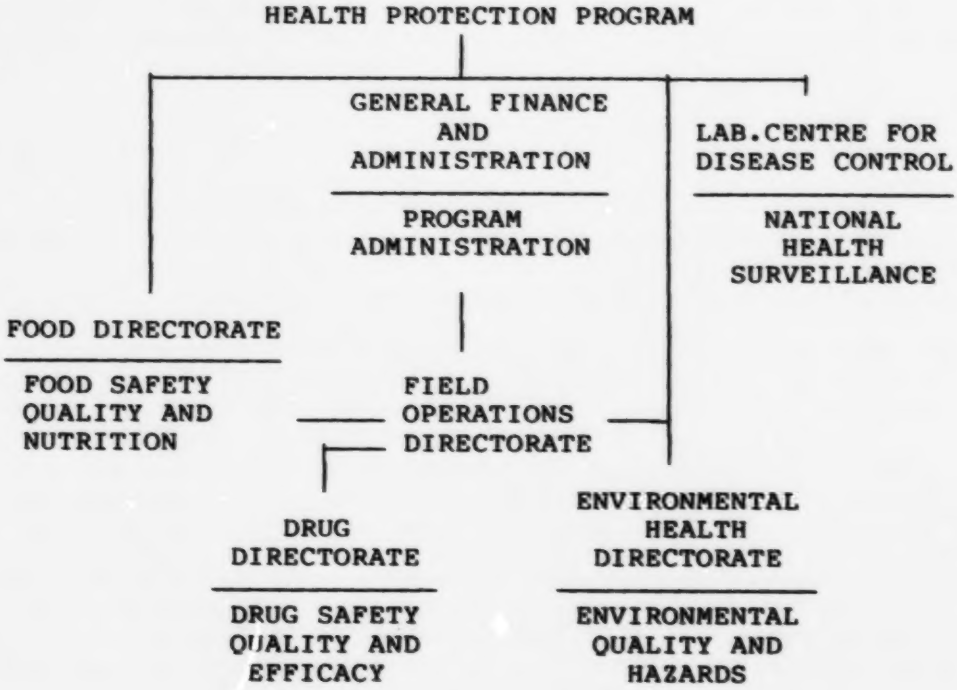
The family of regulatory programs concerned with health protection includes:

* Food Safety, Quality and Nutrition - HWC 100
Drug Safety, Quality and Efficacy - HWC 101
Environmental Quality and Hazard - HWC 102

All three programs are located in the Health Protection Branch of Health and Welfare Canada (HWC).

Resources

Health Protection Program Activity Structure


HEALTH PROTECTION PROGRAM
GENERAL FINANCE AND ADMINISTRATION
PROGRAM ADMINISTRATION
LAB.CENTRE FOR DISEASE CONTROL
NATIONAL HEALTH SURVEILLANCE
FOOD DIRECTORATE
FOOD SAFETY QUALITY AND NUTRITION
FIELD OPERATIONS DIRECTORATE
DRUG DIRECTORATE
DRUG SAFETY QUALITY AND EFFICACY
ENVIRONMENTAL HEALTH DIRECTORATE
ENVIRONMENTAL QUALITY AND HAZARDS

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* This program is being assessed by an inter-departmental group outside the scope of the Health and Sports Study Team.

2.2 1985/86 Resources by Organization/Activity ($000's and P-Ys)**

Assistant Deputy Minister
Health Protection Branch

	Director General Food Directorate	Director General Drug Directorate	Director General Environ. Health Directorate	Director General Lab. Centre For Disease Control	Director General Field Operations Directorate	Executive Director General Finance & Administration	Activity Totals ($000's, P-Ys)
Food Safety Quality and Nutrition	16,005				14,909		30,914
Drug Safety Quality and Efficacy		30,923			10,281		41,204
Environmental Quality and Hazards			17,287		487		17,774
National Health Surveillance				10,961			10,961
Program Administration						14,730	14,730
TOTAL	16,005	30,923	17,287	10,961	25,677	14,730	115,583
Person-years	258	466	259	189	556	232	1,960

** Data from part III of 1985-86 Estimates.

The Health Protection Branch of Health and Welfare Canada is organized into five line directorates plus the supporting Finance and Administration Directorate. Four of the line directorates - Food Directorate, Drugs Directorate, Environmental Health Directorate and Laboratory Centre for Disease Control are situated primarily in Ottawa. The fifth, the Field Operations Directorate, maintains a small headquarters group, but the majority of staff are located in five regional and 22 district offices across Canada, where they are engaged in inspection, analysis and education tasks within three activities:

Food Safety, Quality and Nutrition
Drug Safety, Quality and Efficacy
Environmental Quality and Hazards

The National Health Surveillance activities are carried out through the Laboratory Centre for Disease Control in Ottawa.

The Health Protection Branch operates 12 laboratory facilities, seven of which are in Ottawa. The remaining five are located in Halifax, Montreal, Toronto, Winnipeg and Vancouver.

Observations

The Health Protection Program has a good reputation nationally in disease prevention and control and compares favourably internationally with Britain, the United States and other countries with similar legislation and programs.

In general, provincial officials interviewed view as satisfactory the role and responsibilities of the Health Protection Program. Specifically, the provinces support the role of the Drug Directorate as the sole regulatory authority for drugs in Canada. The provinces, with the exception of Quebec, view the LCDC as the highest reference laboratory in disease surveillance and control, and as the lead Canadian agency in providing both a valuable and indispensable service. As well, the provinces appear to be quite satisfied with the advisory and regulatory roles performed by the Environmental Health Directorate although there is concern that there is duplication of effort in some areas between the Directorate and some activities in Environment Canada.

The Program appears to satisfy the statutory requirements and those of beneficiaries with respect to the provision of information, exchange of data derived from laboratory based applied research, provision of standards, guidelines and regulations designed to minimize health hazards and the use of consultative mechanisms designed to enhance cooperation and collaboration with beneficiaries for the purposes of peer evaluation of program approaches, research, laboratory methodologies and techniques.

The Drug Directorate has administrative difficulties in complying with the 120-day regulatory requirement for evaluation of new drug submissions and the issuance of Notice of Compliance to drug manufacturers. To a lesser extent, the same slowness in issuing Notices Of Compliance to manufacturers of new medical devices due to cumbersome administrative procedures afflicts the Environmental Health Directorate. Currently, the Health Protection Branch is reviewing all its policies, procedures and guidelines pertinent to the evaluation of new products - drugs and medical devices - with the intent of streamlining such and thereby addressing the complaints of manufacturers.

The Health Protection Branch as the sole regulatory authority with respect to drugs, and to a lesser extent for medical devices, and with responsibility shared with other federal departments and provincial authorities with respect to environmental hazards in general, is aware of the need to balance the interests of the various beneficiaries in any given situation requiring a regulatory-type decision and/or action.

Currently, there is not a fee-for-service approach in place with respect to services provided to manufacturers of drugs and medical devices. It would appear that the Branch should re-examine the fee-for-service approach.

Treasury Board, in 1984/85 allocated additional (20+), person-years to the Drug Directorate to eliminate the new drug submission backlog. All the new positions were not filled in 1984/85. Changes in the hiring processes of the Drug Directorate and/or the Public Service Commission should be examined, so that the Drug Directorate can comply with the 120-day regulatory requirement by October 1986.

The Program Administration component of Health Protection Program represents 15% of the total budget in dollars and 13.4% in person-years.

Options

The study team recommends to the Task Force that the government consider:

maintaining the program components of the Drug Directorate, Environmental Health Directorate and the National Health Surveillance Program (LCDC), subject to the implementation of recommendations in the evaluation reports and those of the Eastman Commission. Consideration should be given to the institution of a fee for service approach to recovery of a portion of the total costs for evaluation of new drugs and drug products ($6 million), of new medical devices ($1 million); and

instituting an immediate review of the hiring procedures within the public service beginning with the specialized staff requirements in the Drug Directorate.

DRUG SAFETY, QUALITY AND EFFICACY

OBJECTIVE

To identify and control dangers to the health of Canadians from drugs or their ineffective or unwise use and to prevent the improper use of dangerous drugs or their diversion from the lawful to the illicit market.

BENEFICIARIES

All Canadians benefit directly due to the minimizing of health hazards through the control of improper, ineffective or unwise use of drugs.

Consumers, health professionals, other federal departments and agencies, provincial departments and agencies, professional and industry associations, institutions, manufacturers, importers, wholesalers and retailers, foreign governments, international agencies and law enforcement agencies benefit indirectly through timely approval of safe and effective drugs for use in the prevention and treatment of illness and the minimizing of improper use and diversion of dangerous drugs from the lawful to the illicit market.

All Canadians benefit indirectly from the establishment, monitoring and control through research-based standards for the manufacturing, licensing, marketing and distribution of safe, appropriately-used and effective drugs.

Consumers, professional associations, other government departments - federal and provincial - other countries, international agencies and law enforcement agencies benefit directly from exchange of research data, information and advice.

Manufacturers, wholesalers, retailers, importers and dispensers of drugs are subject to regulation.

AUTHORITY

The major statutes comprising the legal mandate for the Health Protection Program and hence the Drug Safety, Ouality and Efficacy activity are: the Department of National Health and Welfare Act, the Food and Drugs Act and the Narcotic Control Act. Other ancillary Acts include the Broadcasting Act and the Consumer Packaging and Labelling Act.

RESOURCES ($000's) and (PYs)

Expenditure by Budget Element

Expenditure	**82/83** Actual	**83/84** Actual	**84/85** Actual	**85/86** Estimate	**86/87** Projected
Salaries and Wages	22,485	24,640	25,630	27,746	27,745
Other O&M	9,978	10,155	9,512	11,999	12,022
Grants and Contributions	0	0	0	0	0
Capital	2,031	2,264	2,075	1,459	2,620
TOTAL	34,494	37,059	37,217	41,204	42,387
Person-years	656	656	634	672	673
Revenues	5,354	5,339	5,087	5,261	5,100

* Data supplied by HWC - Health Protection Branch.

Expenditure by Activity Elements

Expenditure	83/84 Actual		84/85 Estimate**		85/86 Estimate	
	$	P/Y	$	P/Y	$	P/Y
Drug Safety and Efficacy	16,705	323	20,010	350	19,401	341
Control of Dangerous Drugs	11,112	122	12,307	122	11,522	125
Quality of Marketed Drugs	9,242	211	9,213	206	10,281	206
TOTAL	37,059	656	41,530	678	41,204	672
Revenue	5,339		5,261		5,261	

** Data from Part III of 1985/86 Estimates.

The Drug Safety, Quality and Efficacy activity accounts for 35.6% of total expenditure and 34.3% of the total person-years in the Health Protection Program. Revenue is derived from the charging of prosecution fees, fines and disposal of seized assets as a result of prosecution under the Food and Drugs Act and the Narcotics Control Act. This revenue is not used as an offset against program activity expenditure.

DESCRIPTION

The Drug Safety, Quality and Efficacy activity is divided into three sub-activities. The Drug Safety and Efficacy sub-activity and the Control of Dangerous Drugs sub-activity are carried out by the Drugs Directorate based in Ottawa. The Quality of Marketed Drugs sub-activity is conducted by the Field Operations Directorate, with a small headquarters group based in Ottawa and staff located in five regional offices and laboratories in Halifax, Montreal, Toronto, Winnipeg and Vancouver and in 22 district offices and four sub-district offices located across Canada.

The concentration of major drug manufacturers in Toronto and Montreal means that the Field Operations Directorate through its offices and laboratories in these two cities, carries out the majority of inspections of drug manufacturers. In its role as the federal and sole authority for the regulation of drugs in Canada, the Drug Directorate liaises on an ongoing basis with provincial health authorities and law enforcement agencies, through the RCMP as the coordinating agency, with the Solicitor General, the Department of Justice, Revenue Canada - Customs and Excise, Agriculture Canada, with respect to the use, abuse and diversion of drugs by health professionals, hospitals, consumers and the drug industry. Using existing research data and laboratory-based applied research techniques, the Drug Directorate program activity is responsible for:

> Ensuring the timely acceptability for marketing in Canada of safe and effective drugs, their continued safety and effectiveness after approval and their judicious use. Expenditure estimates in 1985/86 for this activity carried out by the Drug Directorate are $19,401,000 with 341 person-years. Over the past several years, there has been a steady increase in the number of submissions (950 submissions projected for 1985/86 with an expenditure of $4.8 million and 110 person-years) resulting in a lengthy backlog. It is anticipated that increased resource levels (20 additional person-years) approved during 1984/85 will reduce the backlog for new drug submissions.
>
> Ensuring that narcotic and controlled drugs for medical use are manufactured and sold in accordance with Canadian and international control requirements and that an appropriate legislative and control framework exists for prohibited narcotic, controlled and restricted drugs. Expenditure estimates for 1985/86 for this activity carried out by the Drug Directorate are $11,522,000 with 125 person-years.
>
> Ensuring that marketed pharmaceutical products (prescription, non-prescription and veterinary drug products) are manufactured to, and conform with established standards of drug quality, safety and efficacy. Expenditure estimates for 1985/86 for this activity carried out by the Field Services Directorate are $10,281,000 with 206 person-years.

In summary, the Drug Safety, Quality and Efficacy Program activity includes the conduct of research into health hazards associated with the use of drugs and drug products; establishment of safety, quality and effectiveness standards and regulations; premarket evaluation of products according to standards; surveillance, promotion and enforcement of industry and product compliance with standards and regulations; provision of laboratory analyses services to the Solicitor General; provision of information to health professionals to ensure the safe and effective use of drug products and to consumers regarding drug safety; monitoring of dangerous drug use and identification of abuse; control of the movement of dangerous drugs from the lawful to the illicit market.

EVALUATIONS

As a result of the 1982 and 1985 Auditor General's Reports on HWC programs, the Health Protection Branch has undertaken the upgrading and renewal of laboratory facilities and laboratory procedures to minimize occupational health hazards in accordance with the recommendations in the report.

Currently, a review of the regulations, guidelines and procedures associated with all pre-market evaluation processes for food, drugs and medical devices is being conducted within the Health Protection Branch. For example, a procedure is being developed for investigation of new drugs whereby a drug manufacturer, having notified the Drug Directorate of its intent to start pre-clinical or clinical testing of a new drug, would automatically proceed if there is no response from the Drug Directorate within 60 days.

An evaluation of the Drug Safety, Quality and Efficacy program components is in the planning stage, (i.e. the development of the evaluation framework), and is expected to be carried out by the Program Evaluation Directorate over the next several months.

Regional office operations were the subject of internal audits by HWC in 1980 and 1983 and were found to be efficient and effective.

Proposals for revisions to the Food and Drug Act and the Narcotic Control Act are currently being considered by HWC.

Regular use by the Drug Directorate of expert advisory committees promotes peer evaluation of research and laboratory methodologies and the development of new and revised program directions and operations.

The Report of the Commission of Inquiry (Eastman) on the Pharmaceutical Industry (established under Order-in-Council, P.C. 1984-1298) had as a mandate the making of "recommendations for the development of a framework of policy for the pharmaceutical industry in Canada, including policies and programs under the control of both provincial and federal governments". Some of the recommendations which the commission made are pertinent to the Drug Safety, Quality and Efficacy program. They were based on streamlining procedures within the Health Protection Branch and on addressing ways of balancing the interests of both consumers and the drug manufacturing industry. The report recognized the shared responsibility of the Department of Consumer and Corporate Affairs and the Department of Health and Welfare Canada in a number of areas related to the pharmaceutical industry.

The Eastman Report submitted to the Minister of Consumer and Corporate Affairs in February 1985, is currently being used by the Minister as the basis for further consultation with interest groups.

The Canadian Pharmaceutical Association (CPA) in a letter to the Health and Sports Study Team leader dated October 11, 1985 noted that the Health Protection Branch's "review of new product submissions is unacceptably slow" as noted in the Eastman Commission's Report.

As a result of consultations with officials of provincial and territorial governments, it is the view of the study team that the role and responsibilities of the Drug Directorate as the sole regulatory authority for drugs is quite satisfactory.

OBSERVATIONS

The regional laboratories located in Toronto and Montreal which are currently being upgraded are the laboratories through which activities pertinent to the inspection and regulation of the Quality of Marketed Drugs as a sub-activity are mainly carried out.

Following a court challenge by a drug manufacturer in 1984 with respect to non-compliance by the Drug Directorate with the 120-day limit for response to new drug submissions for pre-market evaluation, an increase of 20 person-years was granted to the Drug Directorate. The process of recruitment and hiring of new staff in accordance with Public Service Commission standards and procedures is slower than anticipated with the result that the original schedule for resolving the 'backlog of submissions problems' may not be attained. Compounding this "slow hiring" problem is the requirement for lengthy on-the-job training of new employees in order that they can competently apply the detailed, complex and rigorous criteria, standards and regulations associated with pre-market evaluation of new drug submissions.

The Canadian standards for evaluation of new drugs prior to approval for marketing appear to be more stringent than those of the U.K. and of the U.S., if one compares the length of time it takes from the investigation of new drugs (pre-clinical) stage to the market stage: U.K. six months, U.S. 12 months and Canada 18 months. The Drug Directorate is accused by the pharmaceutical industry of not recognizing the validity of testing results from foreign regulatory agencies (U.S. Drug and Food Administration).

Consideration is currently being given to the regulation of minerals, vitamins and health foods by the Drug Directorate. Risk analysis should be undertaken prior to extension of regulation to these areas.

Currently, there is a dispute within the pharmaceutical prescription drug industry between manufacturers of two types of drugs - innovative and generic. Innovative manufacturers (representing 90% or over $1 billion in sales) are required to invest extensively in the discovery and development of new products. Generic manufacturers simply copy the discovery and do not have to undertake lengthy pre-clinical and clinical research and therefore produce the drug at much lower cost and are able to offer lower prices to the consumer.

The non-prescription (proprietary) drug industry ($1 billion annual sales) confirms the complaints of the prescription drug industry with respect to pre-market evaluation backlogs. This industry complains that the regulatory control on labelling and advertising by the Drug Directorate is excessive.

The pharmaceutical industry complains that the Drug Directorate focuses on regulation of low-risk issues such as labelling and does not adequately address the potential for increased self-regulation by the industry.

There is ongoing liaison between the Bureau of Veterinary Drugs within the Drug Directorate and its counterpart at Agriculture Canada. The roles appear to be complementary.

Increasing demands from consumers under Access to Information legislation for drug and drug-related product information coupled with the rapid increase in new drugs and drug products requiring approval by the Drug Directorate raises doubts in the minds of study team members about the Drug Directorate's capacity to carry out its current statutory responsibilities.

The Drug Directorate, as the federal and sole authority in the regulation of drugs in Canada must weigh carefully the interests of consumers and the interests of the drug industry in all matters pertaining to drug safety, quality and efficacy which come before the Directorate for action and decision. To achieve this balance, there is a need for an advisory group to the Drug Directorate, representative of consumers and non-pharmaceutical industry, and non-professional interests, which would act as a counterweight to the drug industry interests, particularly to advise in the areas of drug labelling, low-cost generic drugs, drug control and distribution and on consumer education related to promotion of safe and wise drug use.

The existing program evaluation framework of the federal government lacks a focus on regulatory requirements essential to programs which must balance interests, particularly those of a socio-economic nature.

In Canada, the legal sanctions for illicit drug market operations do not include seizure of all assets of the person convicted of unlawful activities. In other words, all other assets may have been retained. In other jurisdictions, particularly the United States, seizure of assets includes all assets, not just those pertaining to the specific criminal offence. Consideration of a similar approach for sanctions imposed on illicit drug manufacturing and distribution in Canada might be given by the Justice Department.

Currently, the Drug Directorate licenses only manufacturers of biological drugs. The focus of the Drug Directorate in this area is on regulation of the manufacturing process as well as on testing of marketed products.

Over the past four years, as a result of Treasury Board requests and on its own initiative, the Drug Directorate has given consideration to the advantages/ disadvantages and costs/benefits of the imposition of a fee for evaluation of manufacturers' submissions for new drugs and drug products. Currently, the Directorate is watching the debate in the United States Congress over the fee-for-service approach proposed for the U.S. Food and Drug Administration. In Britain, a fee-for-service approach is in place whereby there is a partial recovery of costs associated with evaluation of new drugs and drug products. In Sweden, the fee-for-service approach is based on a total recovery of all costs associated with evaluation of new drugs. In France, from the information available, there is no indication of a fee-for-service approach. Prior to the Drug Directorate undertaking a fee-for-service approach to evaluation of new drugs and drug products, consideration would have to be given to the establishment of an equitable basis for assessing charges or imposing fees. As an example, the questions of whether the same fee schedule should apply to innovative and generic drug manufacturers and whether the same fees should be charged for each stage - pre-clinical, pre-market - of the evaluation process, would need to be answered.

OPTIONS

The study team has considered three options:

maintaining the Drug Safety, Quality and Efficacy program in its current structure subject to serious consideration of implementation of the recommendations of the Eastman Commission and instituting a fee-for-service for evaluation of submissions by manufacturers of new drugs and drug products. Consideration should be given to charging a licensing fee to drug manufacturers as one approach to recovering in the range of 20% of the costs of evaluation of new drugs and drug products. The suggested target for 1986/87 for recovery of costs through fees is $6 million;

transferring the statutory responsibilities of the Drug Directorate to provincial governments. This option would require changes in legislation by both levels of government and appears to have no provincial support currently. Given the current context of streamlined government, the decentralization of responsibilities from one central agency to 10 or 12 does not appear to be reasonable; and

establishing an arm's length regulatory agency vested with the current statutory responsibilities of the Drug Directorate. Given the general level of satisfaction with the regulatory performance of the Drug Directorate subject to implementation of improved pre-market drug evaluation practices, the costs of such a change appear to outweigh the benefits.

On balance the study team recommends to the Task Force that the government consider maintaining the Drug Safety, Quality and Efficacy program in its current structure subject to serious consideration of implementation of the recommendations of the Eastman Commission and instituting a fee for service for evaluation of submissions by manufacturers of new drugs and drug products. Consideration should be given to charging a licensing fee to drug manufacturers as one approach to recovering in the range of 20% of the costs of evaluation of new drugs and drug products. The suggested target for 1986/87 is $6 million.

In the view of the study team, the Drug Directorate should not embark on any new regulatory activities, such as regulation of the health food products industry, until the current backlog of submissions for new drugs is completely addressed, the regulatory time frames are reinstated (October 1986) and streamlined procedures for handling new drug submissions are in place.

OBJECTIVE

To identify, assess, investigate and control the effects on health due to man-made and natural environmental hazards such as those related to the use of medical devices and exposure to radiation, chemical and microbiological products in the environment.

BENEFICIARIES

All Canadians benefit directly through the minimizing of health hazards in the environment.

Consumers, other federal departments and agencies, provincial departments and agencies, health professionals, professionals and industry associations, institutions, foreign governments and international agencies benefit indirectly through the advice, assessments, standards, guidelines and regulations for the reduction of health hazards associated with medical devices, radiation sources, chemical products and environmental pollutants.

Manufacturers, importers, wholesalers and retailers of medical devices are subject to regulation. Employees within the federal domain are subject to regulation pertaining to environmental and occupational safety in the workplace.

AUTHORITY

The major statutes comprising the legal mandate for the Health Protection Program and hence the Environmental Quality and Hazards activity are: the Department of National Health and Welfare Act, the Food and Drugs Act and the Narcotic Control Act, the Radiation Emitting Devices Act, the Environmental Contaminants Act and the Hazardous Products Act. Other ancillary Acts or Instruments which support the mandate include: the Clean Air Act, the Pest Control Products Act, the Broadcasting Act, Atomic Energy Control Regulations, Canada Labour Code (part IV, Canada Dangerous Substances Regulations), Financial Administration Act, Water Act, Transport of Dangerous Goods Act, the Fisheries Act and the Motor Vehicle Safety Act.

The Environmental Health Directorate shares responsibility for and assumes the lead federal role with respect to health matters in the administration of:

Environmental Contaminants Act, shared with the Department of the Environment;

Hazardous Products Act, shared with the Department of Consumer and Corporate Affairs;

Atomic Energy Control Act and Regulations, Radiation Emitting Devices Act, shared with the Atomic Energy Control Board; and

Canada Labour Code (Part IV - Dangerous Substances Regulations), shared with the Department of Labour.

RESOURCES ($000's) and (PYs)

Expenditure by Budget Element

Expenditure	**82/83** Actual	**83/84** Actual	**84/85** Actual	**85/86** Estimate	**86/87** Projected
Salaries and Wages	9,014	10,079	10,849	11,043	11,176
Other O&M	4,041	5,088	5,627	5,101	5,113
Grants and Contributions	965	807	837	55	55
Capital	1,119	1,944	1,555	1,575	1,314
TOTAL	15,139	17,918	18,868	17,774	17,658
Person-years	242	280	268	276	279
Revenue	792	858	821	1,000	850

* Data supplied by HWC - Health Protection Branch.

Expenditure by Activity Elements ($000's) and (P-Ys)

Expenditure	83/84 Actual		84/85 Estimate**		85/86 Estimate	
	$000's	P-Ys	$000's	P-Ys	$000's	P-Ys
Environmental Occupational and Medical Device Hazards	17,272	264	17,453	258	17,287	259
Medical Device Quality	646	16	578	16	487	17
TOTAL	17,918	280	18,031	274	17,774	276
Revenue	858		1,000		1,000	

** Data from Part III of 1985/86 Estimates.

The Environmental Quality and Hazards activity accounts for 14.5% of total expenditure and 14.1% of the total person-years in the Health Protection Program.

Revenue is from fees charged for provision of dosimetry (measurement of radiation levels) services.

DESCRIPTION

The Environmental Quality and Hazards program activity is divided into two sub-activities. The Environmental, Occupational and Medical Device Hazards sub-activity is carried out by the Environmental Health Directorate based in Ottawa. The Medical Device Quality sub-activity is conducted by the Field Operations Directorate, with a small headquarters group based in Ottawa and staff located in five regional offices and laboratories in Halifax, Montreal, Toronto, Winnipeg and Vancouver and in 22 district offices and four sub-district offices located across Canada.

The Environmental Health Directorate is responsible for:

The assessment and investigation of the effects on health of environmental pollutants and the provision of advice, standards, guidelines and regulations designed to reduce health hazards associated with chemicals, pesticides, medical devices, radiation sources, consumer products and environmental products. Expenditure estimates in 1985/86 for this activity carried out by the Environmental Health Directorate are $17,287,000 with 259 person-years.

Ensuring that marketed medical devices comply with regulatory requirements and are used in a judicious manner. Expenditure estimates in 1985/86 for this activity, carried out by the Field Services Directorate are $487,000 with 17 person-years.

In summary, the Environmental Quality and Hazards sub-activity is responsible for the assessment and investigation of the health effects of environmental pollutants; assessment and control of medical devices, radiation sources and hazardous products; control of microbiological and chemical hazards associated with medical devices and hazardous products; and in conjunction with other organizational units of HWC, the assessment of the health effects of technological and sociological environments.

EVALUATIONS

As a result of the 1982 and 1985 reports of the Auditor General concerning HWC programs, the department has undertaken the upgrading and renewal of laboratory facilities and occupational safety procedures in Ottawa and in the regions in accordance with the recommended actions.

The Medical Devices component of the program activity was evaluated in 1982 by a seven person Evaluation Committee, appointed by the Health Protection Branch and composed of members nominated by organizations representing health professionals, consumers and industry, and chaired by an external consultant from the United States. The Committee concluded that the Medical Devices program "does not duplicate, overlap or work at cross-purposes with other government programs" and "that the program is necessary, should be continued and with limited additional resources should be encouraged".

Currently the Environmental Health Directorate is taking action consistent with the recommendations made by the Evaluation Committee.

The Environmental Hazards component of the program was evaluated by the Program Evaluation Directorate of HWC in 1984. This evaluation focused on two components: environmental contaminant hazards and radiation hazards. The findings and conclusions of the study determined, "that although the program is generally effective in assessing, identifying and controlling chemical and radiation hazards, there are a few areas where program effectiveness could be improved". Although the Program Evaluation Report indicated that the Environmental Hazards Program should continue in its present form, it also indicated through a series of 16 recommendations that new techniques and mechanisms for delivery should be implemented in order to increase the program's impact and effect.

Currently, the Environmental Health Directorate is completing a plan based on these recommendations for implementation over the next two to three years.

The Report of the Commission of Inquiry (Eastman) on the Pharmaceutical Industry (P.C. 1984/1298) included a recommendation to streamline the issuance of Notices of Compliance for pharmaceutical products and medical devices.

This report was submitted to the Minister of Consumer and Corporate Affairs in February 1985 and is currently being used by the Minister as the basis for further consultations with interest groups. A review of all the pre-market evaluation processes associated with food, drugs and medical devices is currently underway in the Health Protection Branch for the purpose of streamlining all such procedures.

OBSERVATIONS

The Department of Health and Welfare Canada through the Environmental Hazards Program, is the major federal source of research expertise and toxicological advice on matters related to potential hazards to human health from hazardous chemicals and radiation, as well as undertaking regulatory activities. Many departments rely heavily (or solely) on advice from the program to support their own regulatory activities.

As a result of consultations with health officials of the provincial and territorial governments the following points were noted:

> In general, the provinces are quite satisfied with the advisory and regulatory roles and performance of the Environmental Health Directorate.
>
> There is concern about the rapid proliferation of medical devices and whether the necessary expertise for dealing with unsafe devices is available.
>
> There appears to be some duplication of effort within HWC and between HWC and Environment Canada with respect to standards and guidelines on environmental hazards.

The control of toxic chemicals and radiation exposure is a shared responsibility of federal and provincial governments. National standards are established by the federal government; provincial governments may enforce these standards.

A recent Treasury Board study estimated that 24 government departments and agencies and 58 Acts of Parliament were involved in activities related to hazardous chemicals. However, the study concluded that, despite the obvious complexities from such wide involvement, there was sufficient cooperation and coordination to avoid duplication and the interests of the different beneficiaries were well served. Nonetheless, the complexities mean that the staff delivering the program spend a large proportion of their time focusing on relationships instead of on delivery of activities and services.

Of the 300,000 medical devices marketed in Canada annually, 90% are imported. For these devices, the Directorate issues temporary clearance-for-sale licences based on recognition of prior approval by regulatory agencies in the United States and/or the United Kingdom. For devices manufactured in Canada, the Directorate may undertake a full pre-market evaluation. For devices already on the market, the Directorate may undertake a full evaluation if problems are reported. Currently there are 80 person-years devoted to the evaluation and inspection of medical devices in the Directorate. In response to the 1984 Medical Device program evaluation report recommendations, the Directorate has restructured its activities to streamline pre-market evaluation procedures and to provide increased liaison with health professionals (under whose direction devices are prescribed), in order to better identify, inform and remedy hazards associated with the use of these devices.

Balancing the health interests of the public with the socio-economic interests of the medical devices industry; (domestic and import) is becoming a major concern of the Environmental Health Directorate.

Rapid technological change, increasing knowledge about environmental hazards and an increasing number of environmental contamination incidents requiring advice and information raise questions about the adequacy of the current capacity of the organizational structure to cope.

The program has considered the imposition of a fee for evaluation of manufacturer's submissions for new medical devices. A look at other countries showed that in the United States there is no official consideration being given to a fee-for-service approach. In Britain, the government issues a list of medical devices permitted for sale. There is no fee for service for evaluation of devices prior to the issuance of the list. There is no information readily available on current practices in France on fee-for-service for medical devices.

OPTIONS

The study team recommends to the Task Force that the government consider:

> maintaining the Environmental Quality and Hazards program in its current organizational and functional form, subject to implementation of the recommendations made by the 1982 and 1985 Auditor General's Reports, the 1982 Medical Devices evaluation report, the 1984 Environmental Hazards evaluation report and the examination of a fee for service for the evaluation of manufacturers' submissions of new medical devices prior to marketing. A suggested target for recovery of costs associated with the evaluation of new medical devices for 1986/87 should be $1 million;

transferring the current functions and resources of the Environmental Quality and Hazards Program as follows; environmental hazards - water, air and soil components - to Environment Canada; medical devices component to Consumer and Corporate Affairs; radiation emitting devices component to Atomic Energy Control Board; occupational health and safety components to Labour Canada. The rationale for these transfers would be a realignment of functions based on consolidation of legislative authority to simplify access to information and to authorities responsible for the beneficiaries. The costs associated with re-integration of laboratory-based research into four other departments and the resulting decentralized regulatory functions appear to outweigh the benefits;

increasing the resources allocated to the Environmental Quality and Hazards Program, specifically to increase the capacity to evaluate new medical devices prior to marketing and to increase inspections of devices in use. This option is less preferable in light of the fact that the Medical Devices evaluation report recommended only limited additional resources but focused rather in improvement of procedures and practices within the directorate to overcome these problem areas.

The study team recommends to the Task Force that the government consider maintaining the Environmental Quality and Hazards program in its current organizational and functional form, subject to implementation of the recommendations made by the 1982 and 1985 Auditor General's Reports, the 1982 Medical Devices evaluation report, the 1984 Environmental Hazards evaluation report and the examination of a fee for service for the evaluation of manufacturers' submissions of new medical devices prior to marketing. A suggested target for recovery of costs associated with new medical devices for 1986/87 should be $1 million.

INDIAN AND NORTHERN HEALTH

Overview

Programs

The family of programs covered in this overview are:

Indian Health Services - HWC 20
Northern Health Services - HWC 21
Contributions to Territorial Governments for
Hospital/Medical Care - INAC 231

The first two programs are located in the Medical Services Branch of the Department of Health and Welfare Canada and the third program is part of the Northern Coordination and Social Development activity of the Northern Affairs Program in the Department of Indian and Northern Development.

Observations

There is no specific federal legislation requiring the provision of health care services to Indians, Inuit and residents of NWT and Yukon. It has been provided traditionally on the basis of custom and federal policy. It is our view that the provincial and territorial health care systems are mature enough for the federal government to divest itself of the direct provision of health care services and transfer responsibility for delivery to the provinces and territories.

The degree of federal financial responsibility under section 91(24) of the Constitution Act, 1867 is not clear. However, since the federal government has a continuing interest in the social and economic well-being of native people, it chooses to give substance to this interest by accepting responsibility for the health and social welfare of registered Indians and Inuit. The level and kind of services provided should take into consideration the level of health of the native population which, at this point, is lower than that of the general population.

With regard to non-insured health services and benefits, unless some measures are taken to constrain the demand, the total costs (representing $110 million or one-third of INH budget in 1984/85) will continue to escalate and use up resources required in other high priority areas. We believe that the assumption that all natives are needy is wrong, although we acknowledge that they generally are a disadvantaged group.

There is no objective data to evaluate the effectiveness of the National Native Alcohol and Drug Abuse Program (NNADAP), firstly because it is only three to four years old and secondly, because there are no clear evaluation criteria developed yet. We recognize that results achieved by NNADAP in developing leadership and skills in local communities may be as, or more, important than its achievement. However, considering the relatively low level of positive results in similar programs elsewhere, the allocation of greater and greater resources (one-sixth of INH budget) has been based so far more on an act of faith than on anything objective or quantifiable.

OPTIONS

The study team recommends to the Task Force that the government consider:

the Minister of Health and Welfare Canada charging with the responsibility of transferring the delivery of Indian health services to provinces or, failing that, to community-based corporations, by April 1991;

transferring the health services functions currently provided by Northern Health Services to the governments of Yukon and Northwest Territories by April 1, 1988;

developing a policy on non-insured health services whereby status Indians and Inuit receive the same benefits as all citizens of the province in which they reside; benefits above and beyond those provided by the province to its residents should be based on a means test;

maintaining resources for the National Native Alcohol and Drug Abuse Program, which have been growing rapidly over the last three years, at their 1985/86 reference level until a comprehensive program review has demonstrated its effectiveness.

INDIAN HEALTH SERVICES

OBJECTIVE

To assist Indians, Inuit and other eligible Canadians, living south of the 60th parallel, to attain a standard of health comparable to that of other Canadians.

BENEFICIARIES

Insured health services, preventive health services and non-insured health benefits are provided to all Registered Indians and Inuit. Limited health services are provided to Metis and Non-Status Indians.

Categories of beneficiaries

Registered Indians - people who are registered as Indian under the Indian Act and whose names appear in the register maintained by the Department of Indian Affairs and Northern Development (DIAND) (approximately 350,000 in 579 bands in 1984).

Status Indians - this category includes all registered Indians as well as Indians who are entitled to be registered. The terms "Status Indian" and "Registered Indian" are often used synonimously although Medical Services Branch caters only to the Registered Indians.

Non-status Indians - generally includes Indian people or those descended from them who for one reason or another have lost their right to be registered as Status Indians. (approximately 25,000 self-identified for the 1981 Census). Bill C-31 adopted by Parliament in 1985 will reduce the number of Indians in this category and increase it in the first two categories defined above.

The Inuit - the aboriginal inhabitants of Northern Canada (about 22,000 in the Northwest Territories, 5,000 in Northern Quebec and 2,000 in Labrador according to the 1981 Census).

Metis - generally people of mixed aboriginal and European ancestry who distinguish themselves from Indians and Inuit (about 100,000 according to the 1981 Census).

AUTHORITY

The Constitution Acts, 1867 to 1982, section 91, subsection 24 established exclusive federal jurisdiction over Indian Affairs.

The Indian Act, section 73(1) empowered the Governor in Council to make regulations in regard to provision of medical treatment and health services to Indians.

Section 5 of the Department of National Health and Welfare Act established the Department of Health and Welfare Canada's (HWC) responsibility for the promotion and preservation of the health, social security and social welfare of the people of Canada over whom the federal government has jurisdiction.

A 1945 Order-in-Council placed responsibility for Indian health with the Department of Health and Welfare Canada.

RESOURCES ($000's) and (P-Ys)

The resources data in Tables One and Two, below refer to Indian Health Services only. All the subsequent tables in this assessment provide composite data for both Indian and Northern Health Services (NHS) because it was not possible to separate out the two expenditures. Northern Health Services are reviewed elsewhere in this report.

Table One

Resources for Indian Health Services

Expenditure	**82/83 Actual**	**83/84 Actual**	**84/85 Actual**	**85/86 Estimate**	**86/87 Projected**
Salaries	52,015	56,811	61,839	66,703	66,728
Other O&M	82,884	100,439	116,700	114,070	113,410
Capital	9,986	11,599	15,797	16,843	20,077
Grants & Contributions	33,247	47,168	56,779	76,814	90,227
TOTAL	178,132	216,017	251,115	274,430	290,442
Person-years	1,691	1,708	1,783	1,779	1,779
Revenue	11,434	15,449	13,724	15,000	16,000

Source: Figures appearing in the above table and in all other tables used in this report have been provided by Medical Services Branch of Health and Welfare Canada, unless otherwise indicated.

Table Two

Provincial Breakdown of Resources

84/85		Salaries O&M and Capital	Grants & Contributions	Total	Person-Years
NFLD		6,291	4,198	10,489	64
PEI	Atlantic				
NS	Region				
NB					
QUE		14,293	2,474	16,767	143
ONT		54,419	21,823	76,242	530
MAN		32,836	7,753	40,589	362
SASK		30,768	907	37,669	250
ALTA		27,498	5,989	33,487	221
BC		28,237	7,635	35,872	213
TOTAL		194,336	56,779	251,115	1,783

DESCRIPTION

Indian Health Services, until recently a program in itself, is now part of the Indian and Northern Health Services program within the department of Health and Welfare Canada. The program, for planning and reporting purposes, is divided into six components. Following is a table showing the anticipated expenditure for 1985/86 and a description of the services provided under each component for Indian Health Services and for Northern Health Services.

Table Three

Health Services & Estimated Expenditure 85/86
($000's) and (P-Ys)

Expenditure	Community Health	NNADAP	Dental Services	Environmental Health & Surveillance	Hospital Services	Admin.
Salaries	37,881	2,415	3,623	3,147	25,071	21,800
Other O&M	99,720	3,065	24,827	1,273	7,229	10,600
Capital	17,138	---	1,500	300	4,500	2,800
Grants & Contributions	26,046	47,166	---	75	7,660	1,190
TOTAL	180,785	52,646	29,950	4,795	44,460	36,390
Person-years	1,035	66	99	86	685	596

Program Components of Indian and Northern Health Services

Table Four

Community Health Services: ($000's) and (P-Ys)

Expenditure	82/83	83/84	84/85	85/86	86/87
TOTAL	136,829	175,809	182,565	180,785	186,454
Person-years	855	839	1,048	1,035	1,035

Consultative, advisory and technical health services are provided directly at the local community level to prevent illness, promote health and restore health. Other activities in support of the above include the training of nurses, community health representatives and other health personnel as well as the provision of information services. The above services are provided in over 400 communities, mostly in rural and isolated locations.

Following is a sample of the major operating and capital expenditure categories:

- -costs associated with the construction and operation of branch leased, rented, or wholly-owned facilities;
- -costs directly associated with nursing tasks, whether community health or treatment (e.g., drugs, clothing, travel, immunization, etc.);
- -costs incurred by medical professionals (e.g., referral for diagnostic services, consultation, treatment services, drugs, appliances, transportation, etc.);
- -costs associated with the operation of hostel type accommodation and services which are connected with hospitals;
- -costs for non-insured services, etc.

The major occupational groups providing the services are community health nurses, treatment nurses and community health representatives. The majority of persons in the latter group are employed by Indian bands under a contribution arrangement. Other staff employed include physicians, health educators, nutritionists, janitors, interpreters, clerks, etc.

Table Five

The National Native Alcohol and Drug Abuse Program (NNADAP): ($000's) and (P-Ys)

Expenditure	**82/83**	**83/84**	**84/85**	**85/86**	**86/87**
TOTAL	15,749	27,661	31,232	52,646	65,415
Person-years	29	29	54	66	67

This program supports Indian and Inuit people and their communities in establishing and operating programs related to alcohol, drug and solvent abuse. More immediately, it is testing and evaluating a variety of approaches to the programs in order to establish a firm basis for an on-going program run by the native people themselves. Means used to attain the objective of the program include information dissemination, counselling, community project staff training, funding of in-patient and out-patient facilities, research, etc.

Table Six

Dental Health: ($000's and P-Ys)

Expenditure	82/83	83/84	84/85	85/86	86/87
TOTAL	21,979	21,835	29,839	29,950	29,950
Person-years	99	98	102	99	99

Preventive care and education programs are designed to create a greater awareness, particularly among school-age children, of the benefits of oral hygiene. Diagnostic and examination services, emergency dental treatment and annual preventive fluoride programs are provided by program staff and by the staff of several universities. A two-year post-secondary program, funded by Medical Services Branch, is operated at the National School of Dental Therapy in Prince Albert, Saskatchewan, to train dental auxiliaries in the provision of preventive and treatment services in isolated communities and reserves across Canada.

Basic dental care is provided partly by private practitioners and partly by program staff using portable on-site clinics. Services are supplied by dentists, dental therapists, dental hygienists and preventive dental assistants.

Table Seven

Environmental Health and Surveillance: ($000's) and (P-Ys)

Expenditure	82/83	83/84	84/85	85/86	86/87
TOTAL	3,639	4,681	3,760	4,795	4,795
Person-years	86	85	74	86	86

Environmental inspection of communities, water sampling, monitoring of contaminants, collection of data, training of operators, and educational programs are aimed at ensuring safe housing, water supply and waste disposal, controlling insects and rodents, and alleviating the effects of contaminants.

Operating expenditure includes the cost of all laboratory work carried out within the program and analytic services obtained from other agencies or private laboratories. They also include some regulatory services which do not belong to this program, e.g., territorial and local ordinances, common carriers, federal facilities and jurisdictions.

Table Eight

Hospital Services: ($000's) and (P-Ys)

Expenditure	**82/83**	**83/84**	**84/85**	**85/86**	**86/87**
TOTAL	42,010	48,910	39,888	44,460	44,460
Person-years	852	827	720	685	685

Many of the client population live in remote and isolated areas, mostly in the northern parts of the provinces, so services must be accessible as well as available. Because comprehensive health care must include hospital services, the Branch has hospitals in areas and regions where hospital services were not otherwise provided.

Branch hospitals are located in four of the provinces; at Moose Factory and Sioux Lookout in Ontario, at Norway House and on the Pequis Reserve in Manitoba, at Fort Qu'Appelle in Saskatchewan, and on the Blood Reserve in Alberta. Although most hospitals were orginally built principally to serve native Canadians, hospital services are available to anyone in need.

There is great variation among the hospitals in terms of size, complexity, and range of services offered. Hospitals such as Moose Factory General offer a complete array of diagnostic services; medical, surgical, paediatric and obstetric care. The range of services diminishes with size, and in the smaller units only minimal care is available for uncomplicated illness and normal obstetrics, with limited diagnostic services. All hospitals provide services for in-patients and out-patients, part of which is recovered from provincial health insurance plans.

The medical staffing pattern also varies widely. Many are staffed under contracts with university medical schools, and some by private practitioners. Many of the hospitals serve as administrative and logistic bases for field operations, providing medical visitation; radiology; laboratory and pharmacy services; maintenance services; and often food and supplies.

Table Nine

Administration: ($000's) and (P-Ys)

Expenditure	**82/83**	**83/84**	**84/85**	**85/86**	**86/87**
TOTAL	27,981	35,212	38,321	36,390	36,690
Person-years	645	634	545	596	596

This component covers mainly resources expended at regional and zone offices for Indian and Northern Health. It includes administrative support services, contracts and contributions, E.D.P. services, financial services, material management, personnel services, planning and control services, and property management.

Program Delivery Structure

The Indian Health Services program, with headquarters in Ottawa, is a very decentralized program operated by the Medical Services Branch of HWC. At the field level, which accounts for over 90% of program expenditure, the services are provided through a network of seven regional offices (one for each province with the exception of the Atlantic provinces which make up one region), 17 zone offices and 421 local facilities including six hospitals, 55 nursing stations, 109 health centres and 251 other facilities (see table below). Hospitals and zone offices, often co-located, constitute administrative and program centres and the base from which satellite communities are serviced.

Table Ten

Distribution of Beneficiary Population and Program Facilities

	Total Client Population	Isolated Population	Hospitals	Nursing Stations	Health Centres	Other facilities
Atlantic	12,438	0	0	0	7	21
Quebec	25,511	2,891	0	8	13	10
Ontario	74,629	18,235	2	11	23	55
Manitoba	49,956	20,826	2	17	15	27
Saskatchewan	51,075	11,460	1	6	11	62
Alberta	40,820	3,450	1	3	16	19
B.C.	59,543	11,500	-	10	24	57
TOTAL	313,972	68,362	6	55	109	251

Some of the services are provided by federal government employees (2,567 person-years in 1985/86). The greater portion, however, is provided through contractual arrangements with private practitioners, university faculties of medicine, work-sharing arrangements with other levels of government and, increasingly, programs run by the Native communities themselves.

In early 1982, Medical Services Branch employed 641 native people directly and another 533 through contracts (mainly with Indian bands); three years later, the numbers have risen to 681 and 1,357 respectively.

EVALUATIONS

In his 1985 report, the Auditor General reported rather positively on the follow-up and status of the observations he made in 1982 with regard to the management and administration of Indian Health Services. In summary:

- health care standards have been developed to interpret the 1979 Indian Health Policy;
- there is better coordination of activities with DIAND in the delivery of programs;
- revenues will increase with the implementation of new procedures this year;
- contribution agreements are better managed but "the existing MIS's do not yet provide management with enough program information to monitor contribution agreements effectively".

However, in the area of non-insured health services, despite measures implemented mostly on a regional basis, annual expenditure for this category of services continues to escalate.

OBSERVATIONS

Characteristics of the Client Population. Most Indian and Inuit communities are rural. The most marked characteristic is still the isolation in which the people live, cut off from organized services. This isolation holds back the resources needed for a higher standard of living. It makes transportation and delivery of supplies and equipment both costly and difficult.

There are proportionally more native people living below the poverty line than the population generally. Limited access to public utilities, a lack of potable water, sewage and water disposal problems and inadequate housing probably contributes to higher rates of respiratory, digestive and infectious diseases as well as to higher death rates.

Eligibility for Indian Health Service. Eligibility for services is described here for the various categories of beneficiaries and by program benefits. However, one additional distinction is made for Status Indians between those living on-reserve (70% in 1978) and those generally receiving services through provincial health care systems.

	Status Indian On-Res.	**Status Indian Off-Res.**	**Non-Status Indian**	**Inuit**	**Metis**
Community Health	X			X	
Non-Insured Health Benefits (contained within community health)	X	X		X	
National Native Alcohol & Drug Abuse Program (NNADAP)	X			X	
Alcohol Treatment (sub-component of NNADAP)	X	X	X	X	X
Environmental Health & Surveillance	X			X	
Hospital Services	X			X	
Professional Health Career Development (sub-component of Administration)	X	X		X	
Bursary Program (sub-component of Administration)	X	X	X	X	X

Trends in Program Expenditure. (Indian and Northern Health). From 1982/83 to 1985/86, program expenditure has increased from $248 million to $349 million; person-year utilization has remained almost level, going from 2,521 to 2,568. The main factors responsible for the 41% increase in expenditure over a period of three years, mostly in Indian Health, are as follows:

-non-insured health services (drugs, glasses, transportation, etc.) which cost $80 million in 1982/83 will probably reach $130 million in 1985/86; and

-during the same period, the National Native and Drug Abuse Program will have increased from $16 million to $53 million, a $37 million increase.

These two expenditure items have been met mainly from new funds. The small increase in person-year resources (less than 2% and less than the population increase), has occurred because natives have been encouraged to assume local control and management of their health services. This thrust is reflected in the increase in grants and contributions which over the same three-year period, have risen from $36 million to $82 million, an increase of $46 million (for NNADAP largely but also for other native involvement in health at the community level), as well as in the number of native people employed through personal service contracts or service contracts with Indian Bands (533 in 1982, 1,357 in 1985).

Non-insured Health Services. Non-insured health benefits provided to Status Indians and Inuit include transportation for medical reasons (patients and escorts), prescription drugs, dental care, eyeglasses, prostheses and, where applicable, medicare premium and user fees. The above benefits are extended free of charge to all Status Indians and Inuit regardless of place of residence or ability to pay, where these benefits are not provincially-insured. The sole basis for providing these services or benefits, as stated in the Indian Health Policy of 1979, is "... professional medical or dental judgement, or ... other fair and comparable Canadian standards".

The cost of providing non-insured health services has increased from $31 million in 1977/78 ($36 million in 1979/80) to $110 million in 1984/85. In constant dollars (1978 dollars), the increase is still 120%. Future trends will be affected by two major factors. The first factor is a continued increase in the use of these services by Indians and Inuit, due to improved program delivery practices, increased accessibility of services, increased client awareness, and the absence of any means test. The other factor is the impact of Bill C-31 whereby Indians who recover their status will be entitled to these benefits. The additional costs over the next five years are estimated to be in the range of $100 to $200 million.

Impact of Bill C-31: An Act to Amend the Indian Act. The Act will end discrimination based on sex, inherent in the Indian Act and restore status to those persons who were affected. The Bill received Royal Assent on June 28, 1985 and it is effective from April 17, 1985.

Preliminary estimates made by DIAND indicate that 23,000 Canadians will be entitled to be reinstated to both Indian status and band membership while an additional 58,000 will be entitled to regain Indian status only. Some 2,500 are expected to return to reserves. All of the above who apply for Indian status will become eligible for non-insured benefits (where these are not provided by the province or municipalities of residence) while the ones who return to live on reserves will be entitled to all health services. Medical Services Branch estimates that based on experience, the cost of non-insured benefits alone (not including additional manpower and administrative overhead) will amount to $321.90 per capita.

ASSESSMENT

Over the past decades, the program has been effective in improving those health conditions which could be improved by medical care, but not for the conditions related to social and lifestyle factors. There is still a gap in health status between Canada's indigenous people and the rest of Canadians, which program management is addressing through new types of programs (NNADAP, demonstration projects, community health representatives), which encourage greater native involvement in the provision of health services.

Moreover, the health status gap that exists between Canada's indigenous people and the rest of Canadians is a major obstacle to devolving the management and control of health services to local native communities. Program managers feel that, whether or not the transfer takes place, bridging the gap is the main challenge facing those responsible for providing health services to native people. And this means additional money.

There is no objective data to evaluate the effectiveness of the National Native Alcohol and Drug Abuse Program (NNADAP), firstly because it is only three to four years old and secondly, because there are no clear evaluation criteria developed yet. We recognize that results achieved by NNADAP in developing leadership and skills in local communities may be as, or more, important than its achievement in reducing the ill-effects of alcohol and drug abuse. However, considering the relatively low level of positive results in similar programs elsewhere, the allocation of greater and greater resources (one sixth of INH budget) has been based so far more on an act of faith than on anything objective or quantifiable.

With regard to non-insured health services and benefits, unless some measures are taken to constrain the demand, the total costs (representing $116 million or one third of INH budget in 1984/85) will continue to escalate at a fast pace and use up resources required in other high priority areas.

Over the years, the provision of special hospital facilities for Indians and Inuit has been seen as a necessary and desirable development, especially by the provinces (e.g., the Camsell Hospital, Edmonton, provided treatment primarily for Indians and Inuit suffering from tuberculosis). Some of these facilities, including Camsell itself, have been turned over to provinces and are now operated as regular hospitals. Some, however, still operate on an "Indians only" basis and clearly, as at Cardston (Alberta) and Sioux Lookout (Ontario), duplicate the services offered by other hospitals at the same location.

The involvement of the federal government in the direct provision of health services to Indians and Inuit can be traced back in history; it has to do with custom and "gap filling". Granted, the federal government has a responsibility over Indian affairs and direct provision of services may have been the only realistic alternative in the past. However, the health care delivery system in all provinces is sophisticated enough today to look after the health needs of all residents, including natives.

OPTIONS

The study team recommends to the Task Force that the government consider:

- charging the Minister of Health and Welfare Canada with the responsibility of transferring the delivery of Indian health services to provinces or, failing that, to community-based corporations, by April 1991;

- directing the Minister of Health and Welfare Canada to develop a policy on non-insured health services whereby Status Indians and Inuit receive the same benefits as all citizens of the province or territory in which they reside; benefits above and beyond that level should be based on a means test;

- maintaining funds for the National Native Alcohol and Drug Abuse Program at the 1985/86 reference level until March 31, 1988 subject to a comprehensive review of the program conducted by a group from outside HWC with specific expertise in this program area.

NORTHERN HEALTH SERVICES

OBJECTIVE

To assist Indians, Inuit and other eligible residents of the Northwest and Yukon territories, to obtain a standard of health comparable to that of other Canadians.[1]

BENEFICIARIES

All residents of the Northwest and Yukon territories benefit directly through the provision of health services.

AUTHORITY

The Constitution Acts, 1867 to 1982, section 91, subsection 24 established exclusive federal jurisdiction over Indian Affairs.

The Indian Act, section 73(1) empowered the Governor in Council to make regulations in regard to provision of medical treatment and health services to Indians.

Section 5 of the Department of National Health and Welfare Act established the Department of Health and Welfare Canada's (HWC) responsibility for the promotion and preservation of the health, social security and social welfare of the people of Canada over whom the federal government has jurisdiction.

A 1945 Order-in-Council placed responsibility for Indian health with the Department of Health and Welfare Canada.

An April 1954, Cabinet Decision established Northern Health Services as a single agency to serve the medical needs of all northern residents.

RESOURCES ($000's) and (P-Ys)

The resources data presented refer only to Northern Health Services. Composite data for resources for both Indian and Northern Health Services is presented in the Indian Health Services assessment.

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[1] This objective is shared with the Indian Health Services program of the Medical Services Branch of HWC.

Expenditure by Budget Element*

Expenditure	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Estimate	86/87 Forecast
Salaries and Wages	31,090	30,961	31,850	31,039	31,039
Operating Costs	27,764	29,901	34,714	32,651	32,651
Capital	8,695	11,103	11,256	9,395	12,411
Grants and Contributions*	2,506	5,826	*** 8,112	5,323	5,323
TOTAL	70,055	77,791	85,932	74,596	77,612
Person-years	830	775	779	789	789
Revenue**	14,134	27,923	15,994	16,000	16,000

* Data supplied by HWC - Northern Health Services.

** Revenue from reimbursement by territorial governments for hospital and community health care services.

*** Increase due to transfer of Frobisher Bay Hospital to NWT.

Distribution of Program Expenditure - 84/85*
($000's) and (PYs)

Location	Salaries, Operating and Capital	Grants and Contributions	Total ($000's)	Total PYs
Yukon	18,838	702	19,540	313
NWT	58,905	7,012	65,917	465
Ottawa H.Q.	77	398	475	1
TOTAL	77,820	8,112	85,932	779

* Data supplied by HWC - Northern Health Services.

DESCRIPTION

The Northern Health Services of Medical Services Branch (MSB) was established by Cabinet in 1954 to provide both acute care and public health services to all residents in the Yukon (YT) and Northwest Territories (NWT). At that time, Northern Health Services (NHS) took over the responsibility of Indian Health Services north of 60° latitude. The federal government stepped in "temporarily" to provide services because the territorial administrators were unable to adequately meet the health needs in the North.

It was assumed that when the North reached a suitable stage of development, the territorial governments would take over responsibility for health care. NHS carries out the duties of a public health department, providing services such as environmental health - water quality and sewage control, health promotion and communicable disease control. NHS also provides residents with acute care through hospitals and nursing stations where such has not been assumed by territorial governments.

In the 1960s, the territorial governments introduced Hospital and Medical Insurance plans. In the early 1970s when these governments began to demonstrate an interest in assuming greater control over health care, the federal and territorial governments began negotiations to transfer the services provided by NHS to the territorial governments. These negotiations were delayed in 1977 in Yukon and have since become increasingly complicated due to unsettled issues related to native land claims and native self-government in Canada. To date there has been no transfer of services to Yukon. However, in the NWT, one hospital facility at Frobisher Bay, hiring of physicians and patient transportation services have been transferred and discussions continue on the subject.

Health care is provided by Northern Health Services through a variety of facilities based on the health care needs of the community. Health stations (six in the NWT and five in the Yukon) have no resident nursing or medical staff. They may be staffed with Community Health Representatives or a lay dispenser. These units serve as clinics from which visiting doctors and nurses provide treatment or community health services. Health centres (eight in the NWT and ten in the Yukon) are staffed by one or more nurses to provide community health services and emergency treatment. Nursing stations (39 in the NWT and two in the Yukon) are staffed by one or more nurses to provide community health services, treatment and short-term in-patient care. Cottage hospitals (two in the NWT and three in the Yukon) provide continuous nursing service, with a doctor in attendance on a full or part-time basis. General Hospitals (one in the NWT and one in the Yukon) provide continuous primary and secondary care. All hospital services in the North are provided by Medical Services Branch, except for the hospitals at Yellowknife, Hay River, Fort Smith, and Frobisher Bay, NWT, which are the responsibility of the Department of Health, Government of the Northwest Territories. If adequate services cannot be provided at a local facility, transportation and escort services are provided to the nearest major centre usually Vancouver, Edmonton, Winnipeg or Montreal. Frobisher Bay Hospital, transferred from MSB to the NWT government two years ago, currently operates under a community board comprised of natives and non-natives.

All physician services in Yukon are provided by private practitioners for whom transportation allowances are provided by NHS. In the NWT the usual practice is for NHS to contract with the territorial government to provide physician services. The majority of doctors in the NWT, therefore, are under contract with the Government of the Northwest Territories. Physician services in the district of Keewatin have been contracted by NHS to the University of Manitoba through the hospital at Churchill, Manitoba. Additionally there are private practitioners in the larger centres of the NWT who may provide service for NHS.

Specialist services are available in Yellowknife and Whitehorse. Also, through special arrangements with McGill University and the Universities of Alberta and Manitoba, specialists visit the communities in the Territories on a regular basis. With the exception of Old Crow, all communities in Yukon are accessible by road, whereas the majority of the communities in the NWT are isolated and are accessible only by air or water.

The Northern Health Services provide health care in both the areas of prevention. In addition, NHS senior staff provide ongoing liaison with the territorial governments, native organizations and agencies. In each region the program medical officer performs the duties of the territorial medical officer.

The Northern Health Services program is divided into six components similar to those of Indian Health Services. These are:

Community Health Services

A vast array of services - advisory, primary care treatment, technical services and training of personnel - are provided in the local community by community health nurses, treatment nurses, and community health representatives.

These services include health promotion - maternal and child health, nutrition, community health awareness and mental health.

The National Native Alcohol and Drug Abuse Program (NNADAP)

This program supports Indian and Inuit people and their communities in establishing and operating programs designed to reduce alcohol, drug and solvent abuse. More immediately, it is testing and evaluating a variety of approaches to the problem in order to establish a firm basis for an on-going program run by the native people themselves. Means used to attain the objective of the program include information dissemination, counselling, community project staff training, funding of in-patient and out-patient facilities, research, etc.

Dental Health

Preventive care and education programs are designed to create a greater awareness, particularly among school age children, of the benefits of oral hygiene. Diagnostic and examination services, emergency dental treatment and annual preventive fluoride programs are provided by program staff and by the staff of several universities. A two-year post-secondary program is operated at the National School of Dental Therapy in Prince Albert, Saskatchewan, to train dental auxiliaries in the provision of preventive and treatment services in isolated communities and reserves across Canada.

Basic dental care is provided partly by private practitioners and partly by program staff using portable on-site clinics. Services are supplied by dentists, dental therapists, dental hygienists and preventive dental assistants.

Environmental Health and Surveillance

This is a regular field activity undertaken primarily by environmental health officers, and to a lesser extent by community health nurses and community health representatives which involves inspection and surveillance of water quality, sewage and waste disposal, food processing and serving; public health engineering; regulatory services; laboratory analytic services for monitoring outbreaks of diseases; and conducting routine immunization programs.

Hospital Services

The Medical Services Branch has accepted responsibility for health care of Indians and Inuit. Many of the client population live in remote and isolated areas, so services must be accessible as well as available. Because comprehensive health care must include hospital services, the Branch has had to build and maintain hospitals in areas and regions where hospital services were not otherwise provided. Although most hospitals were originally built principally to serve native Canadians, hospital services are available to anyone in need, native and non-native residents of the territories.

There is great variation among the hospitals in terms of size, complexity, and range of services offered (from five beds in the cottage hospitals at Faro to the 120-bed institution at Whitehorse). Hospitals such as Whitehorse General offer a complete array of diagnostic services; medical, surgical, paediatric and obstetric care. The range of services diminishes with size, and in the smaller units only minimal care is available for uncomplicated illness and normal obstetrics, with limited diagnostic services. All hospitals provide services for in-patients and out-patients.

The cost of insured and non-insured health services are borne by the federal government for all status Indians and Inuit. The territorial governments bear the costs for insured health services for the non-native population. Non-insured services for non-natives are the responsibility of individuals.

Distribution of Beneficiary Population and Program Facilities*

Location	**Total Client Pop.**	**Isolated Pop.**	**Hospitals**	**Nursing Stns.**	**Health Centres**	**Other Facil.**
Yukon	24,811	15,000	1	2	10	8
NWT	47,053	36,000	1	39	8	19
TOTAL	71,864	51,000	2	41	18	27

* Data supplied by HWC - Northern Health Services

Financing Arrangements - Federal Contributions

The flow of payments between the federal government and territorial governments with respect to health services is set out elsewhere. In general the federal government is reimbursed by the territories for:

- all uninsured hospital and medical services that it provides to northern residents; and
- community health services provided to non-status Indians and non-Inuit. These costs are apportioned on the basis of ratio of non-native to total population in each territory.

The territorial governments are in turn reimbursed for health services, other than hospital and medical care provided to status Indians and Inuit. This mainly applies to NWT where they have taken over services such as patient transportation.

The Department of Indian Affairs and Northern Development (DIAND) also makes contributions to the territorial governments for health services to Indians and Inuit. These contributions by HWC and DIAND and through EPF are significant.

In essence, the Medical Services Branch, HWC, functions as a provincial Ministry of Health through which the Northern Health Services program acts under contract to the territorial governments to supply essential health services until such time as the territorial governments negotiate a take-over of these services with the federal government.

EVALUATIONS

In October 1985, in a follow-up and status report to his 1982 report, the Auditor General reported that:

> The Medical Services Branch (MSB) has made progress on a comprehensive interpretation of the 1979 Indian Health Policy through development of health care standards and by giving Indians and Inuit a greater role in the delivery of health care services.
>
> There is in 1985 better coordination of activities between HWC and DIAND for the delivery of Indian and Inuit health programs through the appointment of a senior coordinating consultant in MSB and through specific agreements between HWC and DIAND.

Most directives and procedures for ensuring uniform delivery standards for non-insured health services are developed and implemented by MSB on a regional basis.

Most of the recommendations made in the 1982 Auditor-General's Report pertinent to addressing the absence of documented guidelines, inaccurate cost information and the resulting low priority given to the recovery of a large portion of the costs incurred by MSB in providing reimbursable services, have been implemented or will be implemented by December 1985.

The existing management information systems of the MSB do not yet provide management with enough program information to monitor contribution agreements effectively.

An evaluation assessment study presenting four options and approaches for an in-depth evaluation of the Northern Health Services Program was completed by the Program Evaluation Directorate of HWC in May 1985.

OBSERVATIONS

The issue which dominates planning and program delivery activities in Northern Health Services is the transfer of these services from the Medical Services Branch, HWC to the territorial governments. The transfer issue is dependent upon the resolution of constitutional issues pertinent to native self-government and land claims. The Department of Indian Affairs and Northern Development is the designated lead federal Ministry on all these issues, including the transfer of health services subject to consultation with HWC.

In 1981, a proposal to transfer responsibility for health care services to Indian communities was approved by Cabinet on a two-year experimental basis (since renewed for an additional year). Thirty-three communities are now involved in this Community-Based Health Demonstration Program. In addition, Medical Services Branch has developed a Professional Health Career Development Program through which native people can enter health sciences professions and learn to administer community health programs. The latter is essential to the transfer of services to community-controlled facilities.

As noted previously, the direct provision of health services by the federal government was a "temporary" measure until the territorial governments developed the capacity to deliver these services. The governments of the Yukon and N.W.T. now appear ready to take over the direct provision of health services currently provided by Northern Health Services. Negotiations for the transfer of these services are underway in the NWT with the regional director for Northern Health Services acting as the federal team leader.

A joint proposal by HWC and DIAND for tackling the problems of chemical abuse and dependency was approved by Cabinet, leading to the establishment of the National Native Alcohol and Drug Abuse Program.

In the view of the study team, the federal picture with respect to the contribution agreements for the provision of health care services between HWC and the territorial governments, and between DIAND and the territorial governments, is a confused one.

It was noted by both territorial governments that concerns have been expressed by non-native residents as a result of the situation whereby native residents have the costs of non-insured benefits borne by the federal government whereas non-natives bear the costs on an individual basis.

The responsibility for providing Extended Health Care to Indians and Inuit is currently shared between MSB and DIAND; however, for non-natives, the territorial governments bear the responsibility.

OPTIONS

The following options were developed for consideration by the Task Force:

a. Transferring the health services functions currently provided by Northern Health Services to Yukon and NWT governments by April 1, 1988. Given the success of the transfer of hospitals to the NWT, the successful management of the Frobisher Bay hospital by a community board and the expressed intent by MSB to divest its direct health services responsibilities to the territorial governments, this option is preferred. The territorial governments appear to have the desire and the capacity to undertake the direct provision of health services on a basis similar to that of provincial governments.

b. Maintaining the Northern Health Services program in its existing state.

c. Within the context of a streamlined Northern Health Services program, immediate consideration should be given to improving the efficiency and effectiveness of the provision of treatment and preventive health services north of 60°, that is, by Northern Health Services in the Yukon and NWT. Immediate improvements could be achieved by the Medical Services Branch of HWC by:

 - adopting a policy whereby there is consistency and equity among all residents, native and non-native, receiving non-insured health benefits and extended health care benefits in the Yukon and NWT, by April 1, 1987;
 - effecting through this policy a rationalization and capping of expenditures at the 1986/87 levels for the provision of non-insured health benefits to natives by April 1, 1987;
 - taking the lead role in establishing a mechanism wherby HWC and DIAND can review the contribution agreements, establish the total sources of federal funding, and assess and monitor the total federal expenditure for health care services to the Yukon and NWT;
 - through consultation with DIAND and other federal departments, eliminating any duplication of federal funding to Indian and Inuit organizations for health services within native communities;
 - ensuring that the training of health professionals and para-professionals within the Indian and Inuit communities conforms with the schedule for the proposed transfer of responsibilities for the provision of health services to these communities;
 - freezing NNADAP funding at the 1985/86 resource reference levels immediately, until evaluation by an expert group, external to the program, is completed and approved by MSB;

- integrating the approach to the transfer of health services, currently provided by Northern Health Services, with the approach being developed by DIAND for the move to self-government by Indian and Inuit communities. This does not imply a relocation of Northern Health Services to DIAND but at a minimum, there should be an integration of the policy development processes between HWC and DIAND.

The study team recommends to the Task Force that the government consider transferring the health services functions currently provided by Northern Health Services to the governments of the Yukon and the Northwest Territories by April 1, 1988.

Once the transfer of the health services functions currently provided by Northern Health Services of MSB is accomplished, the Northern Health Services program could be abolished.

Subject to the above, immediate consideration should be given to improving the efficiency and effectiveness of the provision of treatment and preventative health services north of 60°, that is, by Northern Health Services in the Yukon and NWT. Immediate improvements could be achieved by the Medical Services Branch of HWC by:

- adopting a policy whereby there is consistency and equity among all residents, native and non-native, receiving non-insured health benefits and extended health care benefits in the Yukon and NWT, by April 1, 1987;
- effecting, through this policy, a rationalization and capping of expenditures at the 1986/87 levels for the provision of non-insured health benefits to natives and a rationalization of extended health care benefits to native and non-natives in the Yukon and NWT by April 1, 1987;
- taking the lead role in establishing a mechanism whereby HWC and DIAND can review the contribution agreements, establish the total sources of federal funding, assess and monitor the total federal expenditures for health care services to the Yukon and NWT;
- through consultation with DIAND and other federal departments, eliminating any duplication of federal

funding to Indian and Inuit organizations for the purposes of health consultation within native communities;

- ensuring that the training of health professionals and para-professionals within the Indian and Inuit communities conforms with the schedule for the proposed transfer of responsibilities for the provision of health services to these communities;
- freezing NNADAP funding at the 1985/86 resource reference levels immediately, until evaluation by an expert group, external to the program, is completed and approved by MSB.

CONTRIBUTIONS TO TERRITORIAL GOVERNMENTS FOR HOSPITALS/ MEDICAL CARE OF INDIANS/INUIT

OBJECTIVE

To provide financial assistance in the form of contributions to the territorial governments for health care (hospital services and medical care) for Indians and Inuit.

BENEFICIARIES

Indians and Inuit in Northern Canada.

AUTHORITY

Appropriations Act. The broad authority comes from the federal government's responsibility for services to natives and to the special relationship to the territories.

RESOURCES - CONTRIBUTION FOR HEALTH CARE ($000's)

Expenditure	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Estimate
Hospital Service	$ 9,540	$ 8,515	$23,128	$15,341
Medicare	2,091	1,675	4,813	2,511
TOTAL	$11,631	$10,190	$27,941*	$17,852
Contribution broken down by Territory				
Yukon	$ 1,805	$ 1,484	$ 2,279	$ 1,689
NWT	9,826	8,706	25,662	16,163
TOTAL	$11,631	$10,190	$27,941	$17,852

Data supplied by DIAND
*Includes previous year's arrears.

The payments are provided under the Northern Coordination and Social Development Branch of the Northern Affairs Program of the Department of Indian Affairs and Northern Development (DIAND).

DESCRIPTION

Under the Established Program Financing (EPF) program the NWT and Yukon (as with all provinces) receive a per capita amount (currently $444) in taxes and cash as the federal contribution toward insured hospital and medical services and for extended health benefits.

In addition, there are separate contribution agreements between the Minister of Indian and Northern Affairs and

- the Yukon, to cover the total cost (less the EPF contribution) of hospital and medical care for indigent status Indians. For purposes of the hospital agreement, 95% are assumed to be indigent. In the case of medical care the payment is for the premiums of status Indians who do not have their premiums deducted at their employment.
- the Northwest Territories to cover the total cost (less the EPF contribution) of hospital services for status Indians and Inuit who are indigent (assumed to be 95%) and of the total cost (less EPF contributions) of medical care for status Indians and Inuit.

The current agreements cover the fiscal years of 1983/84, 1984/85 and 1985/86.

OBSERVATIONS

The combination of the very high cost of hospital and medical services for native persons and the high proportion of natives to the total population in the territories would place a heavy burden on the budgets of the NWT and Yukon if the actual costs were not picked up by the federal government. This contribution enables the territories to offer programs and services of a standard comparable to those provided in other provinces.

The payments flowing back and forth between the federal and territorial governments in respect of health services present a confusing picture (see Attachment 1).

To the extent that amounts for health services show up in the federal books as expenditure and offsetting revenue, the expenditure budget is inflated. Given accounting systems employed in government, there is no easy way to overcome this fact.

This policy of paying the actual cost of hospital and medical services for Indians and Inuit is not followed in provinces.

ASSESSMENT

There does not appear to be an overlap in payments under this program; however, it is difficult to be certain.

No agency of the federal government seems to have a "handle" on the payments for health services being made to the NWT and Yukon.

The expenditure of the federal government (but not net cost) could be reduced by transferring responsibility for all service delivery to the NWT and Yukon and then reimbursing them for services provided to natives.

OPTIONS

Leave the contribution program with DIAND but assign Health and Welfare Canada a lead role in monitoring and assessing total federal expenditure for health services in the North.

Status quo. This arrangement will be advantageous as responsibility for service delivery devolves to the territories. However, it leaves funding for health services in the North in two different federal departments, at least in the short run.

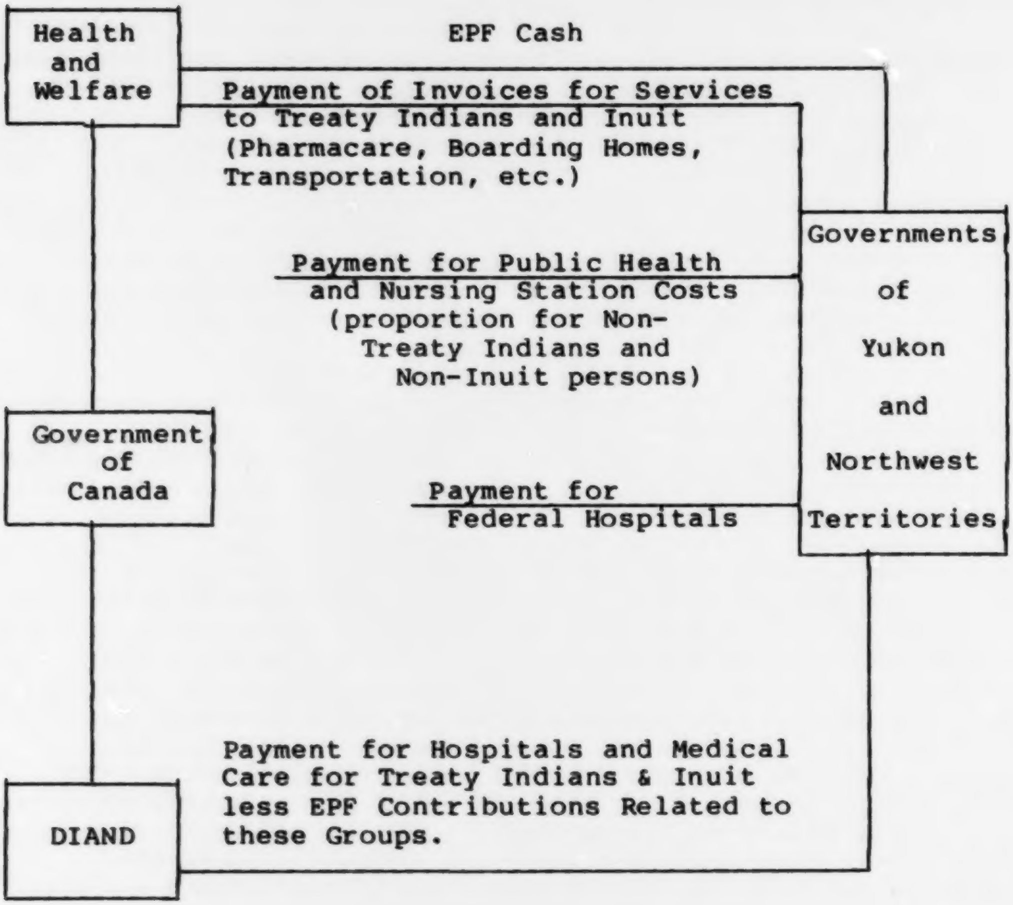
Transfer the responsibility for the contribution program to Health and Welfare Canada. This would eliminate possible confusion and overlap regarding the funding of health services in the North.

The study team recommends to the Task Force that the government consider leaving the responsibility for the contribution program with DIAND but assigning HWC a lead role in monitoring and assessing total federal expenditures for health services in the North. The organizational arrangement is consistent with the suggestion for the long-run but permits better control of health care funding in the short run.

Upon divestiture of the health delivery responsibility to the territorial governments (see Northern Health Services program assessment) this contribution program would be collapsed into the total funding for health and other services provided to the territorial governments.

ATTACHMENT 1

PAYMENTS BETWEEN THE FEDERAL GOVERNMENT AND THE TERRITORIES IN RESPECT OF HEALTH SERVICES FOR NORTHERN RESIDENTS


Health and Welfare
EPF Cash
Payment of Invoices for Services to Treaty Indians and Inuit (Pharmacare, Boarding Homes, Transportation, etc.)
Governments of Yukon and Northwest Territories
Payment for Public Health and Nursing Station Costs (proportion for Non-Treaty Indians and Non-Inuit persons)
Government of Canada
Payment for Federal Hospitals
Payment for Hospitals and Medical Care for Treaty Indians & Inuit less EPF Contributions Related to these Groups.
DIAND

DIRECT SERVICES TO OTHER FEDERAL CLIENTELE

Overview

Programs

The family of programs comprising Direct Services to other federal clientele is the result of grouping together three program activities: Health Assessment and Advisory Services; Prosthetic Services; and Emergency Services.

Options

Some options to deal with the circumstances described in the subsequent program assessments are highlighted here for consideration by the government.

Public Service Health

In light of the rapid increase in costs, the technical complexities of the subject matter and the potential impact on public service collective agreements, it is not possible to make specific proposals on this program. However, we suggest that tenders be called for consulting firms with demonstrated experience and expertise in human resource management and, in particular, the areas of employee and occupational health, to make recommendations regarding:

- appropriate objectives for the Public Service Health function;
- the appropriate organizational placement and structure of the current Public Service Health function;
- the level of resources which should reasonably be allocated to public service health;
- appropriate organizational linkages and relationships between the Public Service Health function and other areas of the federal government;
- such other matters as may in the selected consultant's judgement need to be addressed; such as contracting out of components of the Public Service Health function.

In addition, the study team recommends to the Task Force that the government consider:

Civil Aviation Medicine

Directing Civil Aviation Medicine management to ensure the presence of appropriate health standards and of a menu-driven medical examination form by which private physicians can properly assess the physical competency of air crew and air traffic controllers.

Civil Aviation Medical Examiners to certify that their medical examination reports are complete and accurate and to attest to the physical competency of the individuals examined.

Licensing fees be increased to cover the costs incurred in the licensing activity.

Civil Aviation Medicine be located with other components of the air safety program in Transport Canada.

Civil Aviation Medicine resources in support of the air safety program be reduced to 15 person-years and $750,000.

Quarantine and Regulatory Services

Transfering the responsibility for Quarantine Services from the Medical Services Branch to the Health Protection Branch of Health and Welfare Canada, given the proposed changes resulting from the review of other programs in Medical Services Branch, and given the Health Protection Branch's mandate in the detection and containment of communicable diseases.

Immigration Medical Services

In order that all services and activities relating to immigrants have a single focal point in the federal government, Immigration Medical Services be transferred from Health and Welfare Canada to Canada Employment and Immigration Commission and integrated with other aspects of the immigration program; and that the Department of National Health and Welfare Act be modified accordingly.

Prosthetic Services

The Minister of National Health and Welfare notify provincial governments concerned, that federal Prosthetic Centres which have not been transferred to provincial agencies by April 1, 1986 will terminate their operations at that time.

The Deputy Minister of National Health and Welfare give immediate notice to all Prosthetic Services employees that their positions will become surplus to requirements on April 1, 1986.

No resources be allotted to this program beyond fiscal year 1985/86 except those necessary to give effect to the above proposals, including transfer contributions.

Emergency Services

In light of the fact that there has been minimal use of health and welfare emergency stockpiles and that provinces are responsible for the provision of health and welfare services within their boundaries, we suggest the following:

> Reduce the number of federal emergency supply depots for health and welfare items to two or three strategically located in Canada and transfer to the Department of National Defence the operation and maintenance of these depots.
>
> Dispose of supplies which are surplus to requirements by offering them to the provincial governments free of charge and letting them be responsible for their maintenance or, failing that, by offering them to developing countries.

Emergency training courses be offered on a cost-recovery basis.

First Aid training courses be offered by non-government organizations, e.g., St. John's Ambulance, Red Cross, etc.

CIVIL AVIATION MEDICINE

OBJECTIVE

To provide medical advice and assistance in setting standards for civil aviation personnel; to advise on all matters connected with the health of travellers by air.

BENEFICIARIES

Civilian air crews are counselled on matters affecting their health.

Department of Transport is advised on the health and physical competency of civilian air crew.

AUTHORITY

The Aeronautics Act.

Privy Council Minute #94/4516 of October 30, 1946.

RESOURCES ($000's) and (P-Ys)

Expenditure	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Estimate	86/87 Projected
Salaries	1,935	2,240	2,078	2,332	2,332
Other O&M	270	289	464	311	311
Capital	91	279	8	30	30
TOTAL	2,296	2,808	2,550	2,673	2,673
Person-years	43	43	48	46	46

Source: Medical Services Branch, HWC.

DESCRIPTION

The Civil Aviation Medicine component of this program consists of four different activities in support of its advisory role to Transport Canada (TC).

Clinical Assessment: review medical examination reports prepared by private medical examiners and advise TC on the physical fitness of civilian air crews and air traffic controllers for licensing purposes; the development of physical fitness standards and training of medical examiners are also a part of this activity.

Safety Promotion: on request from organizations operating in the aviation industry, give lectures and otherwise promote safety.

Accident Investigation: until October 1984, the Civil Aviation Medicine (CAM) program provided advice to TC on the medical and human factors relating to aircraft accidents; the responsibility for investigation is now that of the Canadian Aviation Safety Board (CASB); until such time as CASB has developed its own medical expertise, Health and Welfare Canada (HWC) has agreed to provide medical investigative and laboratory support services for aircraft accident investigations.

Research and Development: coordination and execution of R&D to improve aeromedical aspects of aviation safety.

The activity is carried out through a headquarters operation in Ottawa, with the Air Transportation Administration and six regional offices co-located with those of TC's Air Administration, and the Civil Aviation Medical Unit in Toronto. Physicians represent about one third of the staff which is otherwise mostly composed of clerical and other support staff. About 50% of staff are located in regional offices, 10% in the Civil Aviation Medical Unit (research and development unit) located in Toronto and 40% in Ottawa.

EVALUATIONS

An interdepartmental task force composed of representatives from Transport Canada, Health and Welfare Canada and the Canadian Aviation Safety Board has studied medical services requirements for Transport Canada's Federal Air Program.

This program has been reviewed by the following Task Force study groups: Regulatory, Transportation, and Citizenship, Labour and Immigration.

OBSERVATIONS

A major change occurred in 1984 in the organization of aviation safety in Canada when the Civil Aviation Safety

Board was created. Until then, all civil aviation medicine advice and support services to Transport Canada had been provided by the CAM program. Functions were transferred from TC and the CAM program to the Safety Board. Thus accident investigations were transferred to the Board while the regulatory function remained with TC. The function of determining causes and contributing factors, including human factors, was also transferred to the Board from the CAM program. The new division of responsibility between the three agencies split civil aviation medical expertise, which is in short supply in Canada, between CASB and CAM. Currently, medical support for accident investigations is, for an interim period, being provided by Health and Welfare Canada under the terms specified in a Memorandum of Understanding dated December 28, 1984 between CASB and HWC. However, the provision of accident investigation medical support by CAM to CASB is at the expense of program resources which should be allocated to its other responsibility of medical support to TC's regulatory function.

The creation of CASB was primarily the result of an inquiry into aviation safety in Canada led by Mr. Justice Dubin following an airline crash at Cranbrook, B.C. In his inquiry report, Mr. Justice Dubin also raised other concerns. Among the concerns affecting the CAM program more directly, were the need for better training of Civil Aviation Medical Examiners (CAME), for more safety promotion and for more research and development. The impact of these additional requirements on program resources was analyzed by an interdepartmental task force composed of representatives from TC, CASB and HWC. The recommendations of this task force are contained in a report entitled "Civil Aviation Medical Services Required by the Federal Government" dated June, 1985. Over and above the addition of 16 P-Ys in CASB for medical investigations and laboratory support purposes, the above report recommends an additional 13 P-Ys for CAM, five of which are earmarked for research and development, eight in support of the regulatory function and safety promotion activities.

The Interdepartmental Task Force report on "Civil Aviation Medical Services required by the Federal Government" has produced detailed figures on workload statistics and associated person-year requirements. Extrapolating from the above report statistics, following are two tables showing the breakdown of person-years expenditure in FY 1984/85 and the person-years requirements for 1985/86.

Person-Years Expended 84/85

84/85	**Ottawa HQ**	**Regional HQ**	**Camu (R&D)**
Medical Assessment	9*	19.8*	-
CAME Training	-	2.2	-
Safety Promotion	-	1.5	-
Accident Investigation	-	1.1	-
Research & Development	-	-	5
Management & Admin.	6	4.4	-
TOTAL	15	29.	5

Estimated Person-Years 85/86

85/86	**Ottawa HQ**	**Regional HQ**	**Camu (R&D)**
Medical Assessment	21*	12.5*	-
CAME Training	-	3.8	-
Safety Promotion	1	4.3	-
Accident Investigation	-	-	-
Research & Development	-	-	10
Management & Admin.	5	4.3	-
TOTAL	27	25.	10

*The shift of person-years from regional to Ottawa HQ in medical assessment is related mainly to computerization of the process.

Since the Medical Assessment activity is by far the one which consumes the most money and person-years resources (28.8 PYs or 65.5% of total person-years in 1984/85; 33.5 or 64.4% of new requirements, excluding overhead costs) we have concentrated our review on it. This activity directly supports TC's regulatory function. There are approximately 78,000 aeronautical licence holders in Canada (pilots and other flight crew, air traffic controllers, etc.) who must submit to periodic medical examinations in order to retain their licence. Some licences are valid for as long as five years, others for six months only. The total workload thus created amounts to some 66,000 medical examinations annually. These medical examinations are conducted by some 850 Civil Aviation medical examiners who are private physicians appointed across Canada by TC on the advice of

HWC. Medical examination reports are sent to HWC for review and the provision of advice by CAM to TC. The review is a partly clerical, partly medical activity; about 60% of assessments are routine, 20% require some consultation and 20% require substantial consultation, this latter category accounting for half of the total medical and clerical time spent on assessments. The main reason given for the large proportion of non-routine assessments resulting in high resource expenditures by CAM is that Civil Aviation Medical Examiners are not properly trained in the field of aviation medicine. Here is how the Interdepartmental Task Force describes the problem in its June 1985 report:

> "One of the activities most often deferred, limited or omitted in the past has been the training of Civil Aviation Medical Examiners. These doctors may know little of the aviation environment on appointment and there is currently no mechanism which might compel them to learn. Each Regional Aviation Medical Officer attempts to hold seminars and conduct visits, but there is no systematic process in any region to ensure that the Civil Aviation Medical Examiners - the doctors who medically examine aeronautical licence holders - are aware of the various stresses and requirements inherent in aviation and their possible interaction with certain conditions and medications. The International Civil Aviation Organization has recently adopted a standard curriculum for such training which Canada has not yet implemented. However, the Director, Civil Aviation Medicine has directed new levels of service to improve the frequency and quality of medical examiner training, and bring Canada into line with the recommended standard."

As one can see, the medical assessment activity and the CAME training activity are complementary means used by CAM management in support of TC's licensing activity. Greater emphasis placed on training will reduce the requirement in medical assessments.

ASSESSMENT

Civil Aviation Medicine expends 65% of its total person-years in the medical assessment activity, that is, in the review of medical examinations conducted by CAME's (private physicians). It is said that this activity is very time consuming because CAME's lack expertise in aviation medicine. Our view is that, if CAME's had a set of adequate standards by which to examine pilots, air traffic controllers, etc., the amount of review in CAM could be reduced quite substantially. Moving further in this trend of thought, we believe that CAME's should attest to the completeness and accuracy of their examinations and to the physical competence of the persons whom they examine. If this were to occur, the licensing activity would become largely a clerical activity recording the results of examinations and monitoring the frequency of physicians to advise on the few special cases.

It is our view that the above licensing activity should operate on a cost-recovery basis.

We have asked ourselves whether Health and Welfare Canada was the proper location for the Civil Aviation Medicine activity and concluded that relocating it in Transport Canada should be seriously considered for the following reasons:

- CAM is not an isolated health program; it is a component of an aviation safety program;
- the CAM medical community interrelates very little with other HWC medical communities;
- all CAM components in Ottawa and in regional headquarters are co-located with TC;
- as CAM is a support activity to TC, the latter is in a better position to assess its safety requirements (part of which are medical) and to ensure accountability than is HWC;
- the arguments used previously to the effect that aircraft accident medical investigators should enjoy some independence vis-à-vis TC does not hold any more with the creation of CASB.

OPTIONS

The study team recommends to the Task Force that the government consider:

- directing Civil Aviation Medicine management to ensure the presence of appropriate health standards and of a menu-driven medical examination form by which private physicians can properly assess the physical competency of air crew and air traffic controllers;

-having Civil Aviation Medical Examiners certify that their medical examination reports are complete and accurate and attest to the physical competency of the individuals examined;
-increasing licensing fees to totally recover the costs incurred in the licensing activity;
-locating Civil Aviation Medicine with other components of the air safety program in Transport Canada;
-reducing CAM resources in support of the air safety program to 15 PY's and $750,000.

QUARANTINE AND REGULATORY

OBJECTIVE

To prevent entry of diseases into Canada; to ensure national support for a prompt, knowledgeable public health response enabling the identification, control and containment of such diseases; to provide health advice to travellers.

BENEFICIARIES

All Canadians are protected from the hazards of entry of quarantinable communicable disease into Canada.

Canadians travelling abroad are counselled on matters affecting their health.

AUTHORITY

The Constitution Acts 1867 to 1982, section 91, subsection II, give legislative authority to the Parliament of Canada for quarantine matters.

The Quarantine Act and Regulations.

RESOURCES ($000's) and (PYs)

Expenditure	**82/83 Actual**	**83/84 Actual**	**84/85 Actual**	**85/86 Estimate**	**86/87 Projected**
Salaries	969	584	557	373	373
Other O&M	385	297	357	289	289
Capital	27	1	-	14	8
TOTAL	1,381	882	916	676	670
Person-years	30	14	10	9	9

Source: Medical Services Branch, HWC.

Note Figures for FY 1982/83, 1983/84 and 1984/85 include some regulatory activities which were not part of Quarantine.

DESCRIPTION

The objective of this program is to promote the health of Canadians by preventing the importation of infectious or contagious diseases into Canada. Through a well established intelligence network, including the World Health Organization, the United States Centre for Disease Control and many other international reporting centres, program officials keep informed of which diseases and areas of the world are currently suspect. Attention is focused on the detection of a limited number of highly infectious and dangerous diseases, e.g. cholera, plague and yellow fever. The monitoring of the situation around the world helps determine what activities should be concentrated on in Canada.

The main activity is quarantine inspections conducted by environmental health officers who, for the purposes of the Quarantine Act, are called quarantine officers. They operate at all major ports of entry (including six international seaports and eleven international airports) and apply the Quarantine Act and Regulations in accordance with Articles laid down by the World Health Organization in the International Health Regulations. Their work is facilitated through an arrangement with Customs and Excise whereby customs officers provide primary inspection and health officials usually only become involved where documents (e.g. vaccination certificates, ship de-ratting certificates) are not valid. The Quarantine Act provides quarantine officers with authority to board any conveyance (ship, aircraft, train, motor vehicle, etc. transporting persons, goods or cargo) to require the production of records or other documents, to request the medical examination of certain suspected persons and to detain any person or conveyance until satisfied that the Quarantine Act and Regulations are complied with. Ships are periodically inspected to ascertain compliance with international sanitary regulations.

Other activities include information for international travellers on immunization requirements and other prophylactic measures in the form of pamphlets distributed to inquiring travellers, travel agencies and public media. This component also controls the designation of yellow fever centres in Canada (there are currently 41) and supplies them with yellow fever vaccines at a cost of $150,000 per year.

EVALUATION

This program has not been evaluated in the past five years.

OBSERVATIONS

Resources allocated for quarantine are thinly spread in Canada and abroad. Ontario, expends $479,000 or 52% of the quarantine budget due to the presence of the headquarters in Ottawa, the importance of international air traffic, the maintenance of an isolation unit at National Defence Medical Centre in Ottawa, and the operation of a health clinic providing direct services (travel advice, immunization, etc.) to members of Parliament and government employees travelling abroad. The Atlantic region spends 23% of the budget, due to the number of international airports and seaports (Gander, Goose Bay, St. John's, Halifax, Saint John, N.B.). The remaining portion is split between Quebec (13%), British Columbia (4%), Alberta (1%) and Overseas (6%). Most environmental health officers who conduct the inspection activity and other Medical Services Branch (MSB) personnel providing quarantine services are also involved in other activities: that is, Public Service Health and Indian health services.

A draft report of an evaluation conducted by HWC on the Health Protection Branch's Laboratory Centre for Disease Control concludes that "the administration of the Quarantine Act is anomalous given Health Protection Branch responsibilities for detection/containment of communicable diseases and its regional presence" and, therefore, recommends "to transfer the responsibility and resources for the Quarantine Act from Medical Services Branch to the Laboratory Centre for Disease Control. The recommendation is based on an observation to the effect that "almost all cases of exotic communicable diseases will be noticed in a community setting rather than a port-of-entry". Faced with an actual occurrence of one such disease case, the report says that the diagnosis and treatment of it and the tracing of community contacts is more in line with Health Protection Branch's mandate than with Medical Services Branch's. Our own observation is that current quarantine resources go mostly towards preventing the entry of infectious and communicable diseases into Canada whereas the above noted report discusses the problem of coping with actual entry of disease into Canada.

ASSESSMENT

To the extent that there have been no major infectious or contagious disease outbreaks in Canada in the recent past, the Quarantine Program can be said to be effective.

There have been major efforts in Medical Services Branch since 1978 to make the program more cost-effective, including the utilization of customs officers for primary line inspection purposes and that of Transport Canada's health staff at airports to take over the work which was previously done by quarantine nurses. It would seem difficult to reduce program resources without compromising the effectiveness of the program and Canada's commitment to the World Health Organization.

There is no duplication between this program and other federal or provincial programs.

We agree with the conclusion of the departmental evaluation study to the effect that the administration of the Quarantine Act relates more closely to the mandate of the Health Protection Branch than to that of the Medical Services Branch. However, considering the existing method of delivery and organization of the Medical Services Branch, such transfer could not be effected with full budget transfer without impacting negatively on other MSB's activities.

The study team recommends to the Task Force that the government consider transferring responsibility for quarantine activities from the Medical Services Branch to the Health Protection Branch of NHW, given the proposed changes resulting from our review of other programs in Medical Services Branch, and given the Health Protection Branch's mandate in the detection and containment of communicable diseases.

IMMIGRATION MEDICAL SERVICES
HEALTH AND WELFARE CANADA

OBJECTIVE

To determine and advise on the admissibility, from a health standpoint, of prospective immigrants to Canada and certain categories of visitors; to make financial provisions for the medical care of immigrants and visitors where entitlement has been determined by Canada Employment and Immigration Commission (CEIC) to be a federal responsibility.

BENEFICIARIES

CEIC is advised on the health and physical competency of prospective immigrants.

Immigrants, refugees and temporary residents receive medical care benefits.

AUTHORITY

The Department of National Health and Welfare Act, section 5(c), invests the Minister with "the inspection and medical care of immigrants".

The Immigration Act and Regulations.

Several Orders-in-Council.

RESOURCES ($000's) and (PYs)

Expenditure	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Estimate	86/87 Projected
Salaries	3,483	3,008	3,339	800	800
Other O&M	1,818	1,846	1,990	165	165
Capital	6	-	8	-	-
TOTAL	5,307	4,854	5,337	965	965
Person-years	71	47	50	28	28

Source: Medical Services Branch, HWC.

Note The major difference in budget figures between 1984/85 and 1985/86 relates to the transfer of 23 person-years and $3,049,000 to External Affairs. Also included in "Other O&M" for 1984/85 is an amount of about $1,400,000 for emergency medical treatment of federally- sponsored refugees which HWC has not received authority to spend beyond FY 1984/85.

DESCRIPTION

The Immigration Act requires that prospective immigrants and other categories of persons who enter Canada (i.e. immigrants and certain categories of workers, visitors and students) must pass a medical examination. Most examinations are conducted in the country of origin by physicians designated by program medical officials. Immigration Medical Services (IMS) staff review the examination reports and assess whether an immigrant's condition poses a danger to Canadian public health; an excessive demand on health or social services; or a risk of not being able to support themselves. Some 144,000 medical reports were assessed in 1984/85; this constitutes the most important activity of IMS. In addition, IMS advises Immigration Canada on regulations as they apply to health related requirements for entry; maintains a roster of designated medical practitioners; makes arrangements, where necessary, for the medical care and hospitalization of newly-arrived immigrants; pays for non-insured health services for persons identified by CEIC as eligible for assistance; and provides advice and assistance to CEIC for special projects, such as refugee projects.

The assessment activity is carried out on a decentralized basis: the Quebec region of Medical Services Branch processes medical examination reports for people who are already in the province (e.g. foreign students) and liaises with the provincial government which is closely involved in immigration issues; other applicants in Canada and in the United States are usually processed by headquarters in Ottawa; all medical assessments for persons examined outside Canada or the U.S. are processed in 14 posts abroad by physicians whose positions were recently transferred to External Affairs (see above note). The day-to-day advice to CEIC and provision of non-insured benefits are carried out mostly in regional offices of Medical Services Branch. The ratio of physicians to clerical and other support staff working in IMS is about one to 2.5.

The 23 physicians whose positions were transferred to External Affairs operate from 14 different cities, some of the larger ones having up to three or four doctors. Offices are located in Port-of-Spain (Trinidad), Mexico City, Kingston (Jamaica), Paris, London, Bonn, Rome, Athens, New Delhi, Abidjan (Ivory Coast), Nairobi, Singapore, Manila and Hong Kong. In addition to Immigration Medical Services, these physicians also provide an occupational health service to Canadians serving in embassies.

EVALUATION

This program has been reviewed by the Regulatory and by the Citizenship, Labour and Immigration study group reporting to the Task Force on Program Review.

OBSERVATIONS

IMS is a component of a regulatory program aimed at preventing the entry of communicable diseases into Canada. It also evaluates the financial burden which the entry of an immigrant may cause on the Canadian health and social services system. It is also partly a social benefit program in that non-insured services for eligible persons in Canada are paid for by the program. The total cost of the program for 1985/86, taking into account the resources transferred to External Affairs for administrative purposes and the cost of uninsured health services paid to various classes of immigrants, will exceed $5.5 million. Our review of the program extends to the total program costs.

The majority of immigrants sponsored by the federal government are healthy individuals who are expected to contribute to the economic life of Canada. However, political instability and violence in a number of countries around the world have become an important contributor to the number of people who have come to Canada. Of the total planned intake of 90,000 immigrants for 1985, it is estimated that the federal government will sponsor 15,000 refugees and accept another 7,000 for humanitarian reasons. The cost of uninsured medical and dental treatment is much higher for individuals falling into the latter categories than it is for the "regular" immigrants. The estimate of $1.8 million provided by MSB for 1985/86 may not be high enough if we give credence to representations made by some provincial government representatives who state that they have to absorb costs which are properly the federal government's responsibility.

ASSESSMENT

The medical assessment activity conducted by External Affairs physicians working abroad and by IMS staff working in Canada is partly duplicating the work of private foreign and Canadian physicians. However, removing the medical examination requirement from the admission process or rejecting persons who enter Canada as immigrants, visitors or temporary workers, or leaving the medical control to private physicians alone would be relinquishing an important element of entry criteria which are the prerogative of the federal government. For this reason, we believe that the medical assessment activity should be maintained.

Immigration Medical Services is not a stand alone health program but a function within a regulatory program.

Refugee operations have often created special and unforeseen workloads for which resources had not been authorized. In the process of getting these additional resources authorized, HWC and CEIC have often gone to Treasury Board separately. It would seem logical that CEIC, as the lead department in immigration matters, should be responsible for coordinating the total immigration requirements, including those relating to medical aspects.

Since immigration is a federal responsibility and since the entry of non-Canadians to Canada is controlled by the federal government, the financial responsibility for health benefits should continue to be assumed by the federal government until such time as these people, whether they entered Canada legally or illegally, acquire landed immigrant status.

OPTIONS

Transfer the Immigration Medical Services function from National Health and Welfare to Canada Employment and Immigration Commission.

Status quo.

The study team recommends to the Task Force that the government consider transfering Immigration Medical Services from Health and Welfare Canada to Canada Employment and Immigration Commission and integrating it with other aspects of the immigration program, in order that all services and activities relating to immigrants have a single focal point in the federal government. The Department of National Health and Welfare Act should be modified accordingly.

PUBLIC SERVICE HEALTH
HEALTH AND WELFARE CANADA

OBJECTIVE

To promote and conserve the health of public servants and other government employees via a comprehensive occupational health service available to all employees on the basis of need.

BENEFICIARIES

All federal government departments are advised on occupational health matters impacting on their employees.

Federal public servants are counselled on matters affecting their health.

AUTHORITY

The Department of National Health and Welfare Act, section 5(e) specifically invests the Minister with: "the promotion and conservation of the health of the civil servants and other government employees".

Treasury Board Occupational Health Policy (TB 698074 of June 12, 1978).

RESOURCES

Public Service Health ($000's) and (P-Ys)

Expenditure	**82/83 Actual**	**83/84 Actual**	**84/85 Actual**	**85/86 Estimate**	**86/87 Projected**
Salaries	7,671	9,791	11,034	15,385	16,055
Other O&M	1,338	1,952	2,887	2,387	2,440
Capital	339	376	998	1,038	1,116
TOTAL	9,348	12,119	14,919	18,810	19,611
Person-years	203	250*	283*	374*	393*

Source: Medical Services Branch, HWC

* Public Service Health (PSH) is one of four components in Medical Services Branch's (MSB) Health Assessment and Advisory Services program, the administration of which, including 27 person-years, is accounted for under the PSH component.

DESCRIPTION

The purpose of this activity is to promote occupational health and safety and provide health services designed to ensure the health and well-being of all federal employees, regardless of location, and to minimize the incidence of work-related illness. Medical examinations, employee counselling and emergency treatment are provided in 88 facilities across Canada. Environmental surveillance and advisory services to management are also provided.

The major outputs of the Public Service Health program per year can be summarized as follows:

- 225,000 employee visits to PSH facilities;
- 39,000 pre-employment and periodic medical examination, that is:
  - 25,000 conducted by program nurses and assessed by program physicians;
  - 7,000 conducted by private physicians and assessed by program physicians;
  - 7,000 conducted by program physicians;
- 30,000 emergency and first-aid treatments;
- 50,000 X-ray and laboratory tests;
- 7,000 injections;
- 450 safety inspections of workplaces by environmental health officers;
- 3,000 counselling sessions re: alcohol, drug, mental health, work placement; and
- 5,000 consultations re: work related health problems.

The above services are provided by a staff of 315, the composition of which is as follows: 28 physicians, 151 occupational health nurses, 39 environmental health officers, 12 employee assistance coordinators and 85 administrative and technical personnel. The staff complement is increasing but has not reached the 374 person-years allocated for 1985/86.

A geographical breakdown of the federal public service clientele is provided below, along with person-years and expenditure for the Public Service Health program in 1984/85.

Fiscal Year 1984/85	No.of Fed.Pub. Servants	No. of P-Ys	Total ($000's) Expenditure
Ottawa Headquarters	-	34	2,657
Ntl.Capital Region	99,337	106	4,519
Overseas Region	1,709*	4	764
Atlantic Region	29,261**	39	1,885
Quebec (excl. NCR)	26,245	33	1,587
Ontario (excl.NCR)	14,500	21	1,295
Manitoba	9,734	8	423
Saskatchewan	5,912	4	228
Alberta	13,028	13	631
British Columbia	20,400	19	854
Yukon	955	2	69
NWT	1,506	-	7
TOTAL	222,587	283	14,919

Source: Medical Services Branch, HWC.

* 1,709 does not include dependants

** 29,261 includes 14,338 in N.S., 7,441 in N.B., 5,440 in Nfld. and 2,042 in P.E.I.

EVALUATIONS

There has been no program evaluation during the past five years. The program has been reviewed by this Task Force's Citizenship, Labour and Immigration study group.

OBSERVATIONS

In December 1983, Health and Welfare Canada made a submission to Treasury Board requesting over a four-year period from 1983/84 to 1986/87, an additional $10,655,000 and 218 person-years over and above the $9,622,000 and 189 person-years provided for in the Estimates for 1983/84. The request for the increased resources was based on the following reasons:

> a relative decline of PSH resources in the period 1974 to 1983 to carry out its increasing responsibilities;
>
> increased awareness on the part of employees and their bargaining agents of workplace conditions that may affect their health;
>
> decentralization of departments;

workloads resulting from the institution of the Employee Assistance Program (a program designed to help employees whose performance has deteriorated due to problems such as alcohol, drug abuse, etc.);

problems in federal government laboratories; and

concerns with health hazards in office buildings, technological change and the advent of office automation.

Treasury Board Ministers approved the following increases:

1984/85	$4,546,000	89 P-Ys
1985/86	$6,220,000	128 P-Ys
1986/87	$7,034,000	147 P-Ys

These additional resources were authorized to allow the occupational health program to be operated in accordance with Treasury Board's standards and requirements specified in its Occupational Health Policy (TB 698074 of June 12, 1970) and subsequent policies, standards and procedures. They had no direct relationship with collective bargaining in the public sector.

The additional resources seem to have been allocated fairly evenly between all regions of Canada except the National Capital Region which was allocated a lesser increase. Viewed from the manpower perspective, the number of employee assistance program coordinators tripled to 12, environmental health officers doubled to 40, occupational health nurses increased by 60 to 150, while the number of physicians remained about constant at 28 to 30, and technical and support staff went from about 55 to 85.

Based on 1985/86 budget allotments, the cost of the PSH program amounts to an annual expenditure of about $85 per employee, which is incurred by the federal government as the employer. The ratio of person-years to number of federal public servants is 1:588. In the United States, the ratio is about 1:750.

The demand for the PSH services fall into two categories: treatment services for which the demand is relatively high and prevention services where the demand is low. There is one important exception to the latter category in that, more and more, public service managers request the services of environmental health officers (EHO) to inspect federal government facilities in response to reported unsafe working conditions. Managers generally comment quite positively on the work of EHO's and seem to know how to use their services. On the other hand, the work of occupational health nurses and physicians, other than for emergency treatment, first aid and like services, is not well appreciated by managers.

ASSESSMENT

There is very little objective effectiveness data which can assist a program review such as this. In fact, the major increase in resources authorized by Treasury Board a couple of years ago was not preceded by a thorough program evaluation exercise.

Since PSH is an occupational health program the purpose of which is mainly the prevention of work-related illness, it is the view of the study team that the program needs a major refocusing of its major thrusts and organization. In regard to program content and activities, it is our view that most activities related to treatment, pre-employment and periodic medical examinations,and the associated laboratory and x-ray tests could be carried out by private physicians and through existing community resources. As for the provision of first aid, the existing number of persons trained and of first aid stations established within departmental operations but outside the PSH program should, if properly deployed, be sufficient to meet current and future demand.

From the existing mix of PSH services and the demand made on them, we conclude that the understanding by public service managers about the purposes and benefits of a good occupational health program is low. This possibly applies to some of the staff providing occupational health (O.H.) services as well. Some resources should be allocated to a better definition of the program, to management awareness sessions (what the program can do for managers and employees, when outside government resources should be used, etc.) and for PSH staff awareness training.

If it is to become more effective, accountability for the results of the PSH program needs to be better defined between Treasury Board, who sets the standards, PSH management, who provide the occupational health services, and departmental management, who are responsible for overall operational results, resource management and staff productivity. Finally, it is the opinion of the study team that both departmental managers and PSH managers should actively participate in the development of O.H. standards with Treasury Board acting as the employer and performance evaluator.

The current deployment of PSH units is designed to make services available to individual employees; this delivery model tends to accentuate the provision of treatment services and the demand for services by individuals which could be obtained in the community.

We are concerned by the magnitude of cost increases in this program.

OPTIONS

In light of the rapid increase in costs, the technical complexities of the subject matter and the potential impact on public service collective agreements, it is not possible to make specific recommendations on this program. However, we suggest that tenders be called on consulting firms with demonstrated experience and expertise in human resource management, and in particular the areas of employee and occupational health, to make recommendations regarding:

- appropriate objectives for the Public Service Health function;
- the appropriate organizational placement and structure of the current Public Service Health function;
- the level of resources which should reasonably be allocated to Public Service Health;
- appropriate organizational linkages and relationships between the Public Service Health function and other areas of the federal government;
- such other matters as may in the selected consultants judgment need to be addressed such as contracting out of components of the public service health function.

The resources for this program should not be increased for 1986/87 pending the results of the study of appropriate objectives for a public health program.

EMERGENCY SERVICES
HEALTH AND WELFARE CANADA

OBJECTIVE

In collaboration with other levels of government, to ensure the provision of health and welfare services under national emergency conditions.

BENEFICIARIES

The intended ultimate beneficiaries are the victims of potential peacetime and wartime disasters, that is, individuals and organizations, who would be provided with the health and welfare services and supplies required under emergency conditions.

The more immediate beneficiaries are:

Provinces and, through provinces, municipalities who are assisted in planning, organizing and operating services to meet the health and welfare needs of people in the event of such disasters.

Individuals who have received the Emergency Training Course.

Federal public servants who have enrolled in the First Aid Training Program.

AUTHORITY

Order-in-Council 1305 (1981) assigned to the Minister of Health and Welfare Canada the responsibility for the establishment and operations of a National Emergency Agency for Health and Welfare (NEAHW).

RESOURCES ($000s) and (P-Ys)

Expenditure	**82/83 Actual**	**83/84 Actual**	**84/85 Actual**	**85/86 Estimate**	**86/87 Projected**
Operating Expenditure	2,049	2,290	2,374	2,343	2,343
Capital Expenditure	10	42	44	18	12
TOTAL	2,059	2,332	2,418	2,361	2,355
Person-years	31	29	31	30	30

DESCRIPTION

The Emergency Services program administered by the Medical Services Branch of Health and Welfare Canada (HWC) is part of an emergency planning network set up through the Emergency Planning Order (P.C. 1981-1305) of May 21, 1981. In this Order, a number of federal ministers are identified and national emergency agencies are established with specific responsibilities. One of them is the National Emergency Agency for Health and Welfare Services with powers, duties and functions as follows:

> Provide assistance and advice to provincial and municipal governments and to any agency in respect of the operation of emergency health and welfare services.
>
> Coordinate and ensure the provision of emergency medical, nursing, hospital and public health services.
>
> Coordinate and ensure the provision of those emergency welfare services consisting of emergency feeding, clothing, lodging, registration and inquiry, and personal services.
>
> Establish and advise the national emergency agencies and departments in respect of health standards for food, water, drugs and pharmaceuticals and exposure to hazardous environments (radiological, chemical or toxic).
>
> Maintain and allocate medical and health supplies and welfare kits from national stockpiles, and requisition and procure additional supplies as required.
>
> Control and allocate medical professional manpower, other than members of the Canadian Forces, and welfare personnel resources.
>
> Ensure the delivery of essential social security and welfare payments and benefits.
>
> Determine or estimate the extent of traumatic or radiation injuries and establish priorities for treatment.
>
> Determine the extent of damage to medical installations and the health and welfare services infrastructure, and determine priorities for repair or replacement.

Direct or coordinate the implementation of mutual transborder arrangements for medical and welfare assistance between Canada and the United States.

The overall coordinating federal agency is Emergency Planning Canada whose Executive Director reports to the Deputy Minister of National Defence. Policy direction is provided by Privy Council Office. HWC has a representative on an Interdepartmental Emergency Planning Committee who advises on emergency health and social services matters.

Emergency Services is involved in four main activities, that is:

Planning, consultation and advice with a view to ensure that plans are prepared for provinces to provide essential health and social services in a national emergency or disaster.

Courses for health and social services personnel to meet the requirements of the provincial emergency services programs.

Training programs so that federal government departments in the National Capital Region meet the first aid training requirements as set out in Treasury Board standards.

Emergency stockpile maintenance so that medical and health supplies and welfare kits are available to allow for a minimum period of seven days' operation on a self-sustaining basis in a major national emergency.

Almost half the program's operating budget (dollar and person-years) is expended on the last activity, that is, the stockpile operation; the other half goes into developing and updating national plans, advising the provinces and providing training services through a staff divided about equally between professionals forming a multidisciplinary team and administrative support staff. Professionals represent the fields of medicine, pharmacy, nursing, social work, home economics and education.

A wide range of drugs, medical and welfare supplies and equipment are stockpiled at various depots and sites throughout Canada. The current market value of these stores is evaluated at $47,039,368. Products which have an expiry date are rotated in and out of the depot through an arrangement with suppliers; the purpose of the rotation, which is done at a small fraction of the cost of replenishment ($500,000 per year) is to ensure the freshness of drugs and other products at all times.

Emergency training is provided mostly at the Canadian Emergency Preparedness College in Arnprior, Ontario. Training assistance is provided on health, social services and special care facilities planning both as part of broader courses sponsored by Emergency Planning Canada and as stand alone emergency health courses provided to health and social services personnel. In addition to the above courses conducted in Arnprior, Emergency Services staff have participated in casualty simulation training programs and casualty simulation exercises conducted by the provinces and have acted as members of critique teams for such simulation exercises conducted within the provinces. Lectures have also been provided on request to groups such as St. John Ambulance, various associations of health professionals, as well as national and international health organizations (e.g. World Health Organization).

EVALUATIONS

None in the past five years.

OBSERVATIONS

The rationale for the stockpiling activity goes back to the Second World War. Stockpiling, as part of wartime planning, was started to provide a capability of augmenting hospital beds and equipment and the caring for injured people. The use of stockpiled supplies and equipment for peacetime emergencies is more recent. The following are examples of Emergency Services participation in response to disasters which have occurred in Canada in the past ten years. In each instance, either health or emergency social services supplies or equipment or consulting services were provided to assist in post-disaster relief.

Port Alice, B.C. - mud slide/flood
Saint Boniface, Manitoba - hurricane
Niagara, Ontario - blizzard
Moose Jaw, Saskatchewan - fire
Sydney, Nova Scotia - emergency blood services supplies
Paulatuk, N.W.T. - air crash
Toronto International Airport - air crash
London and area, Ontario - tornado

Mississauga, Ontario - train derailment
Aylmer and Buckingham, Quebec - Nursing Home and Hospital Fires
Chapais, Quebec - Fire
Barrie, Ontario - tornado
Northern Ontario - forest fire evacuation
Manitoba - forest fire evacuation

In addition, Emergency Services of Health and Welfare was requested through External Affairs and the Canadian International Development Agency (CIDA), International Humanitarian Assistance, to provide medical supplies and equipment for the Guatemala earthquake, Ethiopia and the Sudan drought and the Mexico earthquake.

The demand for Emergency Services courses and other forms of assistance has increased at a fast and steady pace over the past few years and does not seem to have abated yet. Following are statistics on the number of students to whom presentations were made as part of the Emergency Canada Courses (type 1), to students participating in other courses (except First Aid) given by Emergency Services (type 2), to First Aid Training Course participants (type 3), and in training assistance provided to the provinces and territories for sessions of one to five days' duration (type 4).

Number of Students Instructed by Emergency Services

	81/82	**82/83**	**83/84**	**84/85**
Type 1	N/A	328	382	448
Type 2	243	460	532	603
Type 3	1,629	2,063	2,061	2,390
Type 4	270	393	642	938
	2,142	3,244	3,616	4,379

Source: Medical Services Branch, HWC.

These training services are provided free of charge to the users, that is, federal, provincial and municipal governments and private or semi-public organizations.

There are 14 employees working at the Emergency Services Depot in Ottawa; however, two person-years are used to provide a service which does not properly belong there, that is, a publications storage and distribution service to Medical Services and other branches of HWC. Salaries and operating costs for this service are included in the resources figures identified earlier.

ASSESSMENT

In our review of the health and welfare aspects of the Emergency Planning Order, the following factors were taken into consideration:

> The provision of emergency health and welfare services is, in the main, a provincial responsibility; provinces, even local communities, are increasingly better organized to cope with the consequences of peacetime disasters and other emergencies.
>
> The use of supplies and equipment maintained by HWC has so far been restricted to local emergencies.
>
> Considering the means of transportation in existence today, emergency supplies can be moved across the country in a matter of hours.
>
> The increase in the number of health and safety hazards and accidents may result in an increasing demand for emergency health and welfare services and supplies.
>
> The federal government has a responsibility to plan for potential national disasters or other peacetime emergencies, to assist provinces in coping with such emergencies within their boundaries and, as a member of the international community, to provide relief to other countries requiring help.

Current expenditure for health and welfare emergency services fall into three categories: stockpiling, planning and training. As regards stockpiling, it is our view that the requirement for the federal government to keep so many supplies in so many places no longer exists. Two or three depots strategically located in Canada would seem to be sufficient for the federal government to discharge its responsibilities. Supplies and equipment surplus to requirements could be offered to provincial governments for their own use and as a back-up capability, or to Third World countries who have the capability to make use of them. As for remaining depots, the Department of National Defence, considering its peacetime as well as wartime roles, would seem to be well equipped to operate them and make use of them in emergency situations.

The Emergency Planning function per se is not being questioned, inasmuch as what is done in HWC's Emergency Services is part and parcel of and is being coordinated with other federal governments and agencies through Emergency Planning Canada.

The Study Team sees the provision of training as a complement to the advisory role performed by Emergency Services. However, the costs of training should be shared among users, in our view. Charging a fee for training might curb the demands placed on the Emergency Services program; in the absence of a better effectiveness measure, tuition fees would be one way of measuring the real interest of organizations who are sending representatives on these courses.

Our Study Team questions whether there is still a need to train more federal public servants in First Aid at a rate of more than 2,000 per year. Emergency Services alone has trained 10,694 of them in the past six years, not counting federal employees who have received training from other sources such as the St. John Ambulance. It is our view that Treasury Board should assess whether the required numbers have been met and should have any future requirements met through non-government organizations which are already involved in this field. Relieving Emergency Services of this activity would have the additional advantage of permitting the program to concentrate more time on their basic planning role.

OPTIONS

Stockpiles

-Reduction
-Elimination
-Status quo

Emergency Training Course

-Operate on cost-recovery basis (users pay)
-Stop providing training
-Contract out training
-Status quo

First Aid Courses

-Have courses provided by non-government organizations
-Operate on cost-recovery basis (users pay)
-Status quo

In light of the fact that there has been minimal use of health and welfare emergency stockpiles and that provinces are responsible for the provision of health and welfare services within their boundaries, the study team recommends to the Task Force that the government considers the following:

- reducing the number of federal emergency supply depots for health and welfare items to a maximum of three, strategically located in Canada, and transfer to the Department of National Defence the operation and maintenance of these depots;
- disposing of supplies which are surplus to requirements by offering them to the provincial governments free of charge for use in their hospitals or, failing that, offering them to developing countries;
- offering emergency training courses on a cost-recovery basis;
- offering First Aid training courses by non-government organizations, e.g., St. John's Ambulance, Red Cross, etc.

VALUE OF STORES ON DISTRIBUTION

REGIONAL SUPPLY DEPOTS - (DND MANNED)

Chilliwack	- B.C.	$ 1,491,321.	
Calgary	- Alta.	1,972,826.	
Shilo	- Man.	1,845,034.	
Borden	- Ont.	3,774,699.	
Petawawa	- Ont.	3,683,185.	
Valcartier	- Que.	3,218,962.	
Debert	- N.S.	3,311,898.	
	Sub Total	$19,297,924.	$19,297,924.

MEDICAL SUPPLY DEPOTS - EHS

Cambridge	- Ont.	$2,205,010.	
Shawinigan	- Que.	3,805,020.	
Nanaimo	- B.C.	377,156.	
	Sub Total	$6,387,224.	$6,387,224.

PROVINCES & TERRITORIES (approx. 300 pre-positioned sites)

British Columbia		$ 3,075,791.	
Alberta		2,811,598.	
Saskatchewan		1,085,051.	
Manitoba		762,812.	
Ontario		3,547,972.	
Quebec		2,097,379.	
New Brunswick		453,142.	
Nova Scotia		894,998.	
Prince Edward Island		151,454.	
Newfoundland		513,137.	
Northwest Territories		111,405.	
Yukon Territory		24,819.	
	Sub Total	$15,529,558.	$15,529,558.

VALUE OF WELFARE FORMS IN PROVINCES

BLOOD BAGS

- In Provinces	$ 92,972.	
- In Depots (ES)	25,030.	
- In Depots (Red Cross)	240,166.	
Sub Total	$358,168.	$358,168.

OTTAWA DEPOT

Value of stores remaining - including training, warehouse supplies and materiel handling equipment.	$5,113,913.	$5,113,913.
TOTAL		$47,039,368.

PROSTHETIC SERVICES
HEALTH AND WELFARE CANADA

OBJECTIVE

To provide prosthetic and orthotic services to disabled veterans and other persons in need.

BENEFICIARIES

Six thousand eight hundred and fifty-eight (6,858) disabled individuals in five provinces (New Brunswick, Quebec, Ontario, Manitoba and British Columbia) have received fitting and repairs services in six prosthetic centres in 1984/85.

AUTHORITY

Order-in-Council PC 1965-218 on the transfer of prosthetic services from the Department of Veterans Affairs to the Department of Health and Welfare Canada (HWC).

Cabinet Decision 132-77 on the negotiated transfer of prosthetic services centres to other jurisdictions.

RESOURCES ($000's) and (P-Ys)

	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Estimate	86/87 Projected*
Operating Expenditure	3,495	2,417	2,317	2,673	2,673
Capital Expenditure	48	61	48	23	24
Grants and Contributions	1,995	225	-	-	-
TOTAL Expenditure	5,538	2,703	2,365	2,696	2,697
Person-years	78	59	58	62	62
Revenue	1,957	1,275	1,111	1,330	700

DESCRIPTION

The Prosthetic Services Program is involved in the provision, fitting and repair of custom-made medically prescribed prosthetic and orthotic appliances, devices and orthopaedic footwear to physically handicapped veterans - and other Canadians when authorized by an agreement with the provinces. The program is run by the Medical Services Branch of the Department of Health and Welfare Canada. It operates six prosthetic centres in Canada where devices are fitted and repairs are done.

The breakdown of beneficiaries by provinces and the location of centres which were still under Medical Services Branch control on April 1, 1985 is as follows:

Province	No. of Beneficiaries	Location of Centres
New Brunswick	792	St. John's
Quebec	600	Montreal
Ontario	915	London
Manitoba	1,643	Winnipeg
British Columbia	2,908	Vancouver & Victoria
TOTAL	6,858	

The Prosthetic Services Program started after the Second World War mainly to provide services to war amputees. Forty years later, private suppliers are operating in a number of major urban centres and technology has progressed rapidly in the field of prosthetics. The federal government in 1977, approved a policy permitting bilateral negotiations with the provinces to transfer prosthetic centres to suitable institutions operating within the provincial public sector and to create a federal consulting and information centre once all the centres are transferred. Negotiations to date have resulted in the transfer of six facilities located in Halifax, Ottawa, Toronto, Regina, Calgary and Edmonton. The transfer of the London, Ontario Centre to Parkwood Hospital should be completed by January 15, 1986.

EVALUATIONS

There has been no formal program evaluation of Prosthetic Services in the last five years.

OBSERVATIONS

Comparative data between the various prosthetic centres show significant differences in the number of beneficiaries per person-year and in the gross cost (i.e., not accounting for revenues) per beneficiary:

Facilities	No. of Benefi- ciaries	Total Operating Costs ($000's)	Total P-Ys	No. of Benefi- ciaries Per P-Ys	Gross Cost Per Benefi- ciary
St. Johns, N.B.	792	173	4.4	180	$218
Montreal	600	253	7.0	86	$422
London, Ont.	915	283	7.4	124	$309
Winnipeg	1,643	501	12.7	129	$205
Vancouver & Victoria	2,908	846	18.5	157	$291
TOTAL - Field	6,858	2,056	50.0	137	$300
Ottawa HQ	-	309	8.0	-	-
TOTAL-Program	6,858	2,365	58.0	118	$345

Today the prosthetics centres serve less than 10% of the total Canadian market; federal government clients (Veterans Affairs, Royal Canadian Mounted Police and National Defence) together represent 47% of their total clientele.

Plant and equipment is described as "approaching obsolescence". Very little capital has been invested since 1977 while technology has been changing at a fast pace.

The most significant barrier to the successful transfer of facilities is probably their lack of profitability. In 1977, revenue generated from the program represented two-thirds of expenditure; during the last three fiscal years it represented only from 35% to 48% of program costs. Contributions made to effect past transfers have generally been five times the amount of the annual deficit of the centre.

Alternative prosthetic services are available in all cities where HWC prosthetic centres are located with one exception, that is, Saint John, N.B. In this latter case, prosthetic services are provided in Fredericton.

Due to delays in transferring the remaining centres to provincial agencies (because of high operational deficits) the department is looking at the possibility of closing the centres where services are available from the private sector.

Terms of reference have been developed for a National Consulting Service in Prosthetics and Orthotics which would continue to operate following the transfer of the remaining federally operated prosthetic establishments, the purpose of which would be to provide national leadership and support for the development of efficient and effective prosthetic and orthotic services throughout Canada.

ASSESSMENT

It is the view of the study team that the Prosthetic Services Program has now outlived the purpose for which it was established.

To the extent that the program is not operating on a full cost-recovery basis, it can be said that it is competing unfairly with private suppliers of the same devices and services.

The role of a National Consulting Service in Prosthetics and Orthotics is no longer warranted, in our view.

There are growing inefficiencies in the program as prosthetic centres are being transferred; the longer the transfer process, the more difficult it will be to effect them and the more costly these transfers may be to the federal government.

OPTIONS

Terminate the Prosthetic Services program effective April 1, 1986.

Status quo.

The study team recommends to the Task Force that the government consider having the Minister of National Health and Welfare notify the provincial governments concerned that federal Prosthetic Centres which have not been transferred to provincial agencies by April 1, 1986 will terminate their operations immediately.

No resources should be allotted to this program beyond fiscal year 1985-86 except those necessary to give effect to the above recommendations, including transfer contributions.

HEALTH STATISTICS AND DATA

Overview

Programs

The family of programs concerned with health data statistical includes:

Health Status - SC 113
Health Care - SC 117
Information Systems - PPI

Health Status and Health Care are programs located in the Health Division of Statistics Canada. Information Systems is a program located in the Policy, Planning and Information Branch of the Department of Health and Welfare Canada (HWC).

A description of the programs follows. Assessment of the programs and options are presented for the three programs together.

Observations

The collection of health data by three programs (two located in Statistics Canada and one in Health and Welfare Canada) would appear to contribute to a number of problems. With data bases divided between departments, the possibility of duplication and lack of linkage between data bases increases. With no clear leader, the setting of priorities, coordination, implementation of decisions and new initiatives are hampered. As well, statistics are produced by a number of departments and this creates confusion for clients seeking data.

There also appears to be problems with the supply of basic data and the relevance of statistics which are produced.

The provinces supply the basic data to Statistics Canada and Health and Welfare Canada. However, it would appear that the resultant statistics are not very relevant to them and are not much used by them. Partly, this stems from the differing orientations of the two levels of government. Statistics Canada and Health and Welfare collect national, "macro" statistics. The provinces are increasingly interested in ongoing management and administrative issues and are developing their own data collection systems. If the data being produced by the federal government is not being used by the provinces, who were intended to be one of the main beneficiaries of the service, the usefulness of collecting the data must be raised.

Most of the provinces want national statistics but appear to be interested in the federal government collecting a different type of data. One example might be health status data collected through household surveys.

As the provinces continue to set up their own data bases, the data they generate themselves and that which they supply to the federal government will not necessarily be consistent across provinces unless standards are agreed to. The ability to compare statistics between provinces and to produce national statistics would diminish.

Since provinces do not find the current federal statistics very useful, they have little incentive to supply accurate and timely data. This compounds the difficulty at the federal level of producing useful statistics. If the data that the federal government is able to produce is not comparable across Canada and is not timely, the usefulness of collecting and distributing it must be questioned. It becomes then mainly a service for research workers.

The concept of a Health Statistics Centre, along the lines of the Canadian Centre for Justice Statistics, has been gaining increasing attention by both HWC and Statistics Canada. Some of the issues which need to be addressed include scarce resources, dependence upon provincial systems for data (when within these provincial systems, national requirements are receiving reduced attention), and the tendency to maintain data bases with inadequate resources and consequently produce minimally acceptable results. It should be noted that such a centre would not replace the need for provincial systems, and that provinces would need to be involved in any discussions relating to changes in the federal health statistics system. Such a centre might provide the leadership that is perceived to be needed in the collection of national health statistics as well as provide a forum for the reconciliation of the needs of HWC, the provinces, and other clientele of Statistics Canada.

Options

Options to address the first point include:

- Consolidate the collection of health data in either Statistics Canada or Health and Welfare Canada. Statistics Canada has the formal mandate for the collection of health statistics and likely has the better infrastructure for data collection. On the other hand, they must serve a multiplicity of clientele with diverse and competing needs and may not be as sensitive and responsive to immediate and specific needs as Health and Welfare Canada.

- Establish a Health Statistics Centre, along the lines of the Canadian Centre for Justice Statistics, which would have the responsibility for the collection of health data. The Centre would address issues such as scare resources, dependence upon provincial systems for data, data base overlap and quality and usefulness of data. The Centre would need the cooperation of provincial systems, because the basic data come from the provincial system. Such a centre might provide the leadership which is needed in the collection of national health statistics, as well as provide a forum for the reconciliation of the needs of HWC, the provinces, and other clientele of Statistics Canada. If the Centre does not, or is not perceived to have, leadership, it will simply become a fourth player in the federal health information system.

Options to address problems related to the relevance of the data include:

Stop the collection of all health care data for a period of time (1-5 years), while a review of data that is relevant and will be used is undertaken. As user groups make their requirements known, appropriate collection of relevant data can be reinstituted. While this approach would eliminate unnecessary collection of data, cessation of all data collection activities for any period of time would hinder any trend analyses. As well, reintroduction of data bases in response to requests, may lead to disjointed development.

Have the group that has been assigned the mandate to collect health care data review with the provinces and other relevant users, the data that should be collected. The group should probably be given targets for data base reduction and a mechanism to ensure that minority interests do not subvert the intent of the committee. Representatives from the provinces and the federal government should be at a sufficiently senior level to ensure that the data that will be collected will be relevant to the user groups. One mechanism that might be considered is to link the collection of data with some monetary factor. If collection of data is in some fashion going to "cost" a user group, the user group may be more stringent in its "requirements". Because the provinces are both the providers of data and the users of data, this monetary factor needs to be considered carefully.

The study team recommends to the Task Force that the government consider:

-giving Statistics Canada the mandate to collect and distribute all national health data taking into account the views of its major users, that is, Health and Welfare Canada and health ministries in the provinces.

-terminating the collection of current data (i.e., primarily institutional and manpower data) at the national level at a specific date, say January 1, 1987. The Minister of Health and Welfare Canada and the Minister of Supply and Services responsible for Statistics Canada would be asked to convene a Federal/Provincial Forum (Deputy Ministers of Health Conference) to determine; (a) what data should be collected; (b) appropriate mechanisms for the collection and distribution of data. Only where it can be shown that the data will be useful, timely and comparable across Canada should data collection be reintroduced. The Study Team is of the opinion that only by establishing such a time frame will a useful, reasonable and cost-effective data base be developed.

-recovering the major portion of costs incurred in developing, maintaining, and disseminating appropriate statistics from users wholly or partially.

- maintaining the data currently collected by the Health Status Program that is required to be collected by various Acts, Agreements and Orders-in-Council (i.e., vital statistics)
- terminating all other data (i.e., disease registries, environmental health, abortion statistics) as above and subject to the same review.

HEALTH CARE
STATISTICS CANADA

OBJECTIVE

This program provides statistical information, analysis and services which promote an understanding of the nature and operation of the public and institutional components of the health care sector in Canada. The objective is to relate their operations to general societal needs and to provide a basis for policy development, program management and evaluation.

The program develops and promotes the use of common concepts, definitions and classification systems to ensure comparability of statistics. To avoid duplication, it also coordinates with provinces and territories and with other federal government departments the collection and aggregation of national and provincial information on institutions and their operations.

BENEFICIARIES

Major users of the program outputs include Health and Welfare Canada (HWC), provincial departments of health, local and regional health organizations, national and provincial health associations, academics, the media, and the general public. They benefit through an enhanced ability for analysis and decision-making on health care issues.

AUTHORITY

The Statistics Act requires the agency to collect, compile, analyze and publish statistical information on the economic, social and general conditions of the country and its citizens.

The program as it exists today has evolved over time. Vital statistics were part of the original 1919 Charter for the Dominion Bureau of Statistics (see also Health Status program). Hospital statistics were started during the 1930's. Morbidity statistics (in-patient and mental patients) and special care facilities statistics were added shortly after World War II. Health manpower statistics were added in the 1960's when the federal government was involved in assisting provinces financially with professional training programs and with the construction of health research and teaching facilities. Abortion statistics were added following amendments to the Criminal Code in 1969. The nosology centre was added during the 1970's. All additions were responses to government needs of the day established within the broad legislative mandate of the agency.

RESOURCES ($000's) and (P-Ys)

Expenditure	83/84 Actual	84/85 Actual	85/86 Estimate	86/87 Projected
Salaries	2,461	2,307	2,566	2,566
Other Operating	562	495	533	533
TOTAL	3,023	2,802	3,099	3,099
Person-years	85	76	77	77

Source Statistics Canada

DESCRIPTION

The program is delivered by the Institutional Statistics Section, Health Division, Statistics Canada. Statistics are collected from provincial administration files, processed, analyzed, and disseminated in hard copy form (annual and occasional publications, journal articles) and in machine readable form. Data and analyses resulting from ad hoc studies are also provided, usually on a cost recovery basis.

The program includes certain central technical services (for accounting and administrative convenience) which are shared with the Health Status Program (SC 113). These technical services include the Nosology Centre, Operations Centre, and Research and Analysis.

The program provides information on the size, resources, revenues, and expenditures of 1,250 Canadian hospitals and approximately 4,500 special care facilities. Data are also provided on the diagnosis and treatment of the roughly 4.5 million Canadians admitted to hospitals each year. Major data bases include:

- operating characteristics of public, general, and allied institutions (Annual Return of Hospitals, Quarterly Hospital Information System);

-operating characteristics of chronic care institutions (Special Care Facilities Survey);
-registry of health care institutions (Health Care Facility Inventory); and
-medical and demographic characteristics of in-patients (Hospital Morbidity Program, Mental Morbidity Program).This data base is shared with the Health Status Program.

The program also provides limited statistical information on the characteristics of health manpower (nurses, dental hygienists). A technical assistance program provides support to HWC and to provincial departments of health in the development and maintenance of various workload measurement systems.

The program has various consultative mechanisms available to it:

1. Interdepartmental Statistics Canada/HWC Committee with membership at the Assistant Deputy Minister level. The Committee meets periodically to consider major issues in the health statistics field.

2. Sub-Committee on Health Information. This committee reports to the Federal/Provincial Advisory Committee on Institutional and Medical Services. Statistics Canada, Health and Welfare Canada, and each province are members of the sub-committee.

3. Steering Committee for the Development of a Framework for Hospital Management Information System. This committee reports to the Federal/Provincial Advisory Committee on Institutional and Medical Services.

4. Federal/Provincial Committee on Statistical Policy. This committee is advisory to Statistics Canada on all statistical programs (including health).

All data collected are derived from provincial sources (health care administration files).

EVALUATION

This program has also been reviewed by the study team on Major Surveys and the study team on Subsidies and Services to Business.

There has been no recent evaluation of this program.

OBSERVATIONS

Because the data used by Statistics Canada is derived from provincial sources, Statistics Canada is very dependent upon the provincial systems. As provincial health systems have evolved (increased sophistication, varied needs), provinces have become less interested in the national data bases. Each province has different needs and systems, and systems vary within provinces. While provincial officials clearly wish to have national statistics for comparative purposes, provincial statistics are more important to them on a day-to-day basis.

Present data bases (federal and provincial) are case or event based as opposed to patient based. This inhibits the linkage of health status statistics with the financial data contained in health institution revenue and expenditure data bases. There is a recognized need for health status data to be linked with financial data.

The study team has found a degree of confusion among clientele on the mandate of this program and related programs in Health and Welfare. For instance, health manpower statistics are collected by both programs. A lack of a clear leader has also hindered efforts to rank existing and potentially new initiatives, and to develop and implement strategies which will address some of the recognized difficulties with data bases, lack of comparability between provinces, etc.

Timeliness of health care data is a recognized concern. Hospital operational data, for instance, is produced with a lag of 33 months. Part of the delay can be traced to the provinces' reduced sense of urgency for transmitting data to the federal system, as they develop their own management systems.

A majority of provincial officials consulted questioned the relevance and timeliness of national "institutional" data. In general, provinces indicated that their use of this national data was infrequent but when used, it was often at critical times (e.g., budgets). One province expressed the view that there was "too many statistics, and not enough information". This seems to be representative of how most provinces felt. When asked what would happen if they stopped getting national statistics tomorrow the general response was "nothing", in the short run, but caution was expressed about the long run. There seemed to be a desire for selective "macro" statistics from the national level and that the federal government should take the initiative in rationalizing the national data bases.

OPTIONS

Options are outlined in the Overview chapter dealing with the three statistical programs.

HEALTH STATUS
STATISTICS CANADA

OBJECTIVE

Statistics Canada's objective is to provide statistical information and analyis on the social and ecomomic life of Canada, its businesses, its institutions and its people in order to contribute to an understanding of the various aspects of Canada and provide a basis for the development, analysis, and evaluation of social and economic policies and programs, for public, business and individual decision making, and for the general benefit and information of Canadians.

The Health Status program places emphasis on measuring changes in the Canadian population, its demographic characteristics and its health status.

BENEFICIARIES

Health status indicators assist health care providers in measuring progress and improvements in the general health of the nation.

Major users of the program outputs include Health and Welfare Canada (HWC), provincial departments of health, local and regional health organizations, and national and provincial health associations. Other users include academics, the media, and the general public.

AUTHORITY

The Statistics Act requires the agency to collect, compile, analyze and publish statistical information on the economic, social and general conditions of the country and its citizens.

The mandate for the program is based upon the following Acts, Agreements, and Orders-in-Council:

The Statistics Act (1971) section 21;

Order-in-Council (P.C. 163);

Order-in-Council (P.C. 4851);

International Agreement with World Health Organization (WHO);

International Agreement with Pan American Health Organization (PAHO); and

Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act, 1977.

RESOURCES ($000's) and (P-Ys)

Expenditure	**83/84 Actual**	**84/85 Actual**	**85/86 Estimate**	**86/87 Projected**
Salaries	566	588	431	431
Other Operating	136	126	97	97
TOTAL	702	684	528	528
Person-years	18	18	13	13

Source Statistics Canada

DESCRIPTION

Health status statistics are gathered in response to increasing concerns about costs and access to the health care system, the future impact of our aging population and related matters. Substantial information exists about health care institutions, and the costs of treating illness, but comparatively little is known about the health of Canadians in relation to health care expenditures. This limits evaluation of the effectiveness of health care systems and programs designed to promote healthier lifestyles. More information could also shed light on lifestyle and other determinants of good health, as well as on groups which may be disadvantaged with respect to health care.

The program is delivered by the Vital Statistics and Disease Registries Section, Health Division, Statistics Canada. Data are collected, consolidated, analyzed, and disseminated in the following areas:

-vital statistics and disease registries;
-hospital morbidity;

- Canada Health; and
- accidents.

Vital statistics and disease registries consist of four major activities of an ongoing nature:

- production of vital statistics (births, deaths, marriages, and divorces);
- maintenance of a national cancer incidence reporting system;
- conduct of occupational and environmental health statistics studies on an active participating basis with government and non-government sectors; and
- maintenance of disease registries (notifiable diseases, tuberculosis, renal failure).

Hospital morbidity statistics are based upon the characteristics of persons admitted for treatment in Canadian hospitals exclusive of tuberculosis sanitoria and primary psychiatric institutions. Also obtained are statistics concerning the cause of health problems (some provinces) and the nature of the surgical treatment or procedure. The demographic and mental health characteristics of psychiatric in-patients of general hospitals and psychiatric care institutions are also documented. Finally the rate of therapeutic abortions throughout Canada is monitored, as well as related surgical procedures, and selected demographic (i.e., age, marital status) and medical (i.e., previous deliveries, gestation) characteristics of women terminating pregnancies.

During the period in which the Canadian Health Survey existed (July 1978 to March 1979) some 12,000 households (38,000 individuals) were visited. About one-third of the households were directly involved in the physical measures component of the survey (such as blood tests). The Canada Health survey was originally conceived as a larger and continuing survey. Its objectives were to obtain comprehensive and ongoing data on the health status and risk exposure of the Canadian population, including accidents, and to complement existing information which comes primarily from vital statistics and medical care records. The scope of the survey was reduced and limited to a once-only survey in 1978 as part of the government-wide expenditure restraint program of the time. The limited data base that was established is still being used by health researchers, administrators, and analysts for special tabulations and ad hoc analyses.

The accident data base has been in a developmental phase since the expenditure reductions in 1978 and has not progressed significantly. The data base uses vital statistics and hospital morbidity statistics.

The current focus of the Health Status Program is on the development of information about disabled and handicapped Canadians using information derived from sample surveys. A disability survey (nature, severity, characteristics) is under consideration.

Program outputs include the dissemination of publications, journal articles, microtapes, and special tabulations as well as ad hoc studies (conducted on a cost recovery basis).

The program relies on certain central technical services which (for administrative convenience) are accounted for in the Health Care Program (located in the same organizational unit). These technical services include the Nosology Centre, Operations Centre, and Research and Analysis.

The collection of vital statistics has its genesis as part of the original 1919 charter of the Dominion Bureau of Statistics. Hospital morbidity statistics were initiated in the early post World War II period. Abortion statistics were initiated in 1969 when amendments to the Criminal Code were made. Population statistics are required for the administration (by the Department of Finance) for the Established Programs Financing Act, 1977.

The program has various consultative mechanisms available to it:

1. Interdepartmental Statistics Canada/HWC Committee with membership at the Assistant Deputy Minister level. The Committee meets periodically to consider major issues in the health statistics field.

2. Sub-Committee on Health Information. This committee reports to the Federal/Provincial

Advisory Committee on Institutional and Medical Services. Statistics Canada, Health and Welfare Canada, and each province are members of the sub-committee.

3. Working Group on Community Health Information Systems. This group reports to the Federal/Provincial Advisory Committee on Community Health. Statistics Canada and National Health and Welfare are represented on the group along with selected provinces.

4. Vital Statistics Council of Canada. Established in 1945, the council consists of provincial registrars of vital statistics.

5. Federal/Provincial Committee on Statistical Policy. This committee is advisory to Statistics Canada on all statistical programs (including health).

6. Ad hoc expert advisory committees to the Chief Statistician which are set up from time to time.

EVALUATION

This program has also been reviewed by the study team on Major Surveys and the study team on Services and Subsidies to Business.

An evaluation of the program was completed by the Program Evaluation Division, Statistics Canada in May, 1985. When the program evaluation project was conceived, it was concerned solely with the Canada Health Survey because of a legal agreement with Health and Welfare Canada requiring such an evaluation. During the early planning process, the Chief Statistician directed the study to be extended to include a broader range of health status statistics and data bases.

The evaluation yielded three key points:

There is a perceived need for a system of national (as opposed to federal) health statistics. The extent of this need and the means by which it could be fulfilled will require discussion and negotiation among federal and provincial departments and agencies. However, before this can be done, the terms of reference of the various federal departments involved need to be defined more precisely, particularly those of Health and Welfare Canada and Statistics Canada.

The resources made available to the Health Division of Statistics Canada have not kept pace with increases in health research expenditures and general health care.

Many of the criticisms of existing health data can be traced to the structuring of the data bases on events, rather than patients. To move to the latter approach would involve addressing a number of politically sensitive issues, including that of record linkage.

Of the 29 recommendations made in the evaluation report (18 of which were deemed to be purely technical recommendations), attention is drawn to the following three:

- that the Canada Health Survey experience be used as the basis for the development of a new household survey instrument to collect health status data;
- that Statistics Canada initiate discussions with Health and Welfare Canada and the provinces on the establishment of a Health Statistics Centre building upon the experience of the Canadian Centre for Justice Statistics model; and
- that Statistics Canada investigate the feasibility of developing patient-oriented data systems for health status statistics.

OBSERVATIONS

The collection of health data by both Health and Welfare Canada and Statistics Canada has contributed to problems in the area of data base development. While HWC and Statistics Canada have collaborated in the last several years, it is difficult to set priorities and rationalize existing and future data bases. With data bases divided between departments, the possibility of duplication and confusion among clientele is also increased. Also, this presents some difficulty in allocating resources to current and future requirements.

There appears to be general consensus among policy makers and program administrators that the linkage of health status statistics with the financial data contained in the health institution revenue and expenditure data bases of Statistics Canada is a high priority. Currently, policy analysts are unable to identify specific reasons for increased health care costs, nor are they able to assess the impact of measures undertaken to reduce costs.

Systems developed under different provincial jurisdictions do not always use compatible standards or concepts. This leads to serious problems of comparability of data.

Within the program there is a strong sense that the Canada Health Survey experience be used as the basis for the development of a new household survey instrument to collect health status data. Although having substantial start-up costs, an ongoing household survey was felt to be the most cost-effective vehicle for probing the health status of individuals.

A majority of the provincial officials consulted indicated to us that there was a need for health status data and that this need should be met by the federal government. PEI indicated that this was a very important role for the federal government as small provinces simply couldn't undertake the activity on their own. Ontario placed high importance on monitoring health status and indicated they might go so far as to contribute financially to a federal effort in this area. On the other hand, Quebec indicated there was no role for the federal government and indeed they were undertaking a separate health status survey within that province.

OPTIONS

Options are outlined in the Overview chapter dealing with the three statistical programs.

INFORMATION SYSTEMS
HEALTH AND WELFARE CANADA

OBJECTIVE

This program ensures the availability of descriptive and quantitative information on Canadian conditions and programs in the health and welfare field, as required by the Department of Health and Welfare Canada (HWC), for the development of national policies and programs and for the management and evaluation of programs in this field.

BENEFICIARIES

The population served by the program consists primarily of program managers and policy analysts within the health branches of the department and within the health ministries and health insurance commissions of individual provinces.

AUTHORITY

The Department of National Health and Welfare Act provides a general mandate for, "subject to the Statistics Act, the collection, publication and distribution of information relating to the public health, improved sanitation and social and industrial conditions affecting the health and lives of the people".

The Act also provides for "cooperation with provincial authorities with a view to the coordination of efforts made or proposed for preserving and improving the public health...".

RESOURCES ($000's) and (P-Ys)

Expenditure	**82/83 Actual**	**83/84 Actual**	**84/85 Actual**	**85/86 Estimate**	**86/87 Projected**
Salaries	2,386	2,690	2,668	3,202	3,407
Operating Expenditure	903	914	923	956	956
Capital Expenditure	35	65	84	40	40
Grants and Contributions	2,605	2,475	2,637	1,770	1,770
TOTAL	5,929	6,144	6,312	5,968	6,173
Person-years	62	64	64	70	69

Source Corporate Management Branch, HWC

DESCRIPTION

The program is delivered by the Information Systems Directorate, Policy, Planning and Information Branch, HWC. The Directorate is responsible for planning, developing and managing a wide range of health and welfare information systems in support of the analysis, development, and evaluation of social policies and programs. An exact resource breakdown is not possible but it has been estimated, for total expenditure, as 30% health and 70% welfare historically. The expenditures are now shifting towards a 50/50 balance in line with the person-year breakdown. The health resources are displayed below:

	82/83	**83/84**	**84/85**	**85/86**	**86/87**
TOTAL Expenditure ($000's)	1,592	1,719	1,888	2,200	2,421
Person-years	30	30.5	31	34.5	34

Source Policy, Planning and Information Branch, HWC

The Directorate is involved with the collection, processing, analysis and dissemination of information on the social, economic, and health characteristics of the population at large and of specific sub-populations, as well as information on the various aspects of the health and welfare programs (federal and provincial) in Canada. The program coordinates the determination of departmental information requirements to be satisfied by external systems (e.g., Statistics Canada, provinces).

The program provides technical assistance and financial contributions, through the Information Systems Development Program, to provinces and nationally recognized associations for the development of information systems which contribute to national objectives. In 1984/85, projects were initiated in Newfoundland, Manitoba, and with the Canadian Hospital Association, while work continued on projects in New Brunswick, Saskatchewan and British Columbia. Projects in Prince Edward Island, Nova Scotia, Ontario and the Yukon terminated in 1984/85.

The program outputs include informational publications, computer-based information storage and retrieval systems and responses to specific information requests. The program has continued to expand its system of medical care statistics for use by provincial health insurance plan administrators. In addition, its information bases on physicians' earnings, national health expenditures and health manpower are updated and published annually.

The program is responsible for identifying, coordinating, and assisting in determining the priorities of the department's information needs. In this regard the program plays a lead role in the Interdepartmental Statistics Canada/HWC Committee which meets periodically to consider major issues in the health statistics field. The program is also represented (with Statistics Canada) on the Sub-Committee on Health Information which reports to the Federal/Provincial Advisory Committee on Institutional and Medical Services.

EVALUATION

The program has never been formally evaluated. An assessment of its role and mandate within the Department has been conducted within the last two years under contract. The program was audited during the period of January to March 1985.

This program has also been reviewed by the study team on Major Surveys.

OBSERVATIONS

The lack of a formal mandate and authority for the program has contributed to a perception by its clients of a degree of confusion, duplication, and lack of leadership. This perception seems to be strongest among ad hoc and one-time users (e.g., researchers) of the program who simply may not be familiar with the data bases. The formal mandate for the collection of health statistics rests with Statistics Canada. The program has evolved over a period of 15 to 20 years by responding to specific statistical needs of the department and of provinces where Statistics Canada has been unable to meet the demand (due to lack of resources, interest, or priority). The program and Statistics Canada have been working collaboratively in the last several years (a formal liaison mechanism has been established) and believe they have removed any confusion or duplication (except at the margin) that may have existed concerning their respective roles. Statistics Canada takes responsibility for thecollection of "hospital" statistics. This program places its emphasis on medical care or physician statistics.

However, both areas suffer from the perception, and from the fact, of a lack of leadership in health statistics. Aside from the leadership aspect, the question also may be raised as to why one area or the other might not be better positioned to provide the entire service. Statistics Canada has the better technical infrastructure for data collection but it must serve a multiplicity of clients with diverse and competing needs. On the other hand, this program is sensitive and responsive to the immediate and specific needs of the Department for statistics in support of policy development and program management.

New demands are being made on Statistics Canada to provide systems oriented to operational and administrative purposes. A case in point is the current request from provinces for workload measurement systems. While Statistics Canada has the basic data bases for systems of this type, they are not within its formal mandate, which is to collect national statistics, and in a climate of scarce resources, it has difficulty considering such requests.

The program only carries out a broad coordinating role in HWC in the area of health status statistics and indicators, although it recognizes the need and importance of this area.

The program must decide what its requirements and objectives are, and how best to achieve these objectives. Only recently has the program conducted a review of its several data bases and their uses; data bases which have been in existence for up to 20 years. Given the very diffuse clientele within the department (and the provinces) it has been very difficult to set priorities and rationalize these data bases in terms of current requirements.

The resource base for the Information Systems Development Program (financial contributions) appears to be inadequate for provincial needs. Only a few projects can be mounted in any given year. The level of resources was $1.7 million (about 10 projects) in 1984/85, but has been reduced to $800,000 in 1985/86 as a result of the expenditure restraint program. The issues that must be addressed are:

-the appropriateness of federal financial assistance for the development of provincial statistical systems;

- the dependency of national statistical systems on provincial data;
- the allocation of resources; and
- the focusing or targeting of funds to national requirements.

In our consultations with provinces, most indicated that the federal government had an important and legitimate role in the collection and dissemination of health information. Most provinces pointed to the lack of timeliness of national statistics and the need for better marketing of what data is available. At least half the provinces found the physician income and fee schedule data provided by this program to be useful.

OPTIONS

Options are outlined in the Overview chapter dealing with the three statistical programs.

NATIONAL HEALTH SURVEILLANCE
HEALTH AND WELFARE CANADA

OBJECTIVE

The National Health Surveillance program prepares and disseminates information concerning the health status of the Canadian population, establishes laboratory medicine standards and provides laboratory technologies for the purpose of preventing and controlling the spread of disease in Canada

BENEFICIARIES

All Canadians benefit directly through the program's health surveillance and laboratory services designed to enhance early detection, improved diagnosis and control of disease.

Health care professionals, professional associations, institutions, research agencies, federal and provincial departments and agencies, foreign governments and international agencies benefit indirectly through the information, advice assessments, research laboratory methodologies, standards, guidelines and regulations provided by the program.

AUTHORITY

The Department of National Health and Welfare Act (section 5) provides a general mandate to investigate and research the problems of health and welfare, and, subject to the Statistics Act, collect, publish and distribute information relating to public health, improved sanitation, and social and industrial conditions affecting health. The Act also provides a mandate to cooperate with provincial authorities with a view to coordinating efforts made or proposed for preserving and improving public health.

The Laboratory Centre for Disease Control (LCDC) evolved from the former Bureau of Hygiene, created in 1925, and through the transfer to LCDC of the former Division of Epidemiology which was created in 1947.

RESOURCES ($000's) and (P-Ys)

Expenditure by Budget Element

Expenditure	**82/83 Actual**	**83/84 Actual**	**84/85 Actual***	**85/86 Estimate**	**86/87 Projected**
Salaries	7,266	7,647	8,381	7,775	7,775
Operating Costs	1,738	1,952	3,332	2,276	2,276
Capital	675	759	1,007	910	1,209
Grants and Contributions	20	8	5	-	-
TOTAL	9,699	10,366	12,725	10,961	11,260
Person-years	192	191	206	189	189

* Data supplied by HWC - Health Protection Branch

Expenditure by Activity Element ($000's) and (P-Ys)

	83/84		**84/85**		**85/86**	
Expenditure	**Actual**	**P-Ys**	**Estimate****	**P-Ys**	**Estimate**	**P-Ys**
Disease Surveillance	3,269	59	3,192	59	2,560	59
Disease Control	5,691	118	6,419	117	6,833	116
Activity Management and Support	1,406	14	1,576	14	1,568	14
TOTAL	10,366	191	11,187	190	10,961	189

** Data from Part III - Estimates 1985/86

The National Health Surveillance program activity accounts for approximately 9.5% of total expenditure and 9.6% of total person-years in the Health Protection Branch.

DESCRIPTION

The National Health Surveillance program activity consists of three sub-activities; Disease Surveillance, Disease Control Services and Activity Management and Support, the latter as a support activity to the first two. The program is delivered by the Laboratory Centre for Disease Control (LCDC) based in Ottawa. LCDC as the highest reference laboratory in Canada shares its diagnostic and epidemiological expertise through a network of provincial reference laboratories across Canada. All provincial laboratories use the expertise provided by LCDC to varying degrees, depending upon their capacity to undertake specialized laboratory procedures in addition to their routine diagnostic work. For example, the LCDC provides, on request, expert diagnostic services and advice for AIDS HTLV 3 tests, typing of organisms isolated in disease outbreaks and verification of provincial laboratory diagnoses.

The environment in which the National Health Surveillance program operates is one of voluntary compliance by provinces and practitioners with the standards set by the LCDC and one in which there is a need for the national collection and feedback of information in areas in which no single organization operating at the provincial or local level could provide sufficient coverage.

The program has available to it three consultative mechanisms or advisory committees:

Technical Advisory Committee on Public Health Laboratory Services (TAC);

National Advisory Committee on Immunization (NACI); and

National Advisory Committee on Epidemiology (ACE).

These committees are very technical and are not concerned with policy or planning, nor are they linked with the formal Federal/Provincial Advisory Committee structure.

EVALUATIONS

As a result of the 1982 and 1985 Reports of the Auditor General concerning Health and Welfare Canada (HWC) programs, the department has undertaken the upgrading of laboratory facilities and occupational health and safety procedures in LCDC in Ottawa in accordance with the recommendations in these reports.

A 1982 internal audit of the National Health Surveillance activity found that provincial officials view the program as the lead Canadian agency in disease control responsible for providing both a valuable and indispensable service. Recent study team consultations with health officials from governments of the provinces and territories confirmed this 1982 finding.

An evaluation of this program by the Program Evaluation Directorate, HWC is in the process of finalization (expected by November 1985). The evaluation was conducted as part of the normal program evaluation cycle of HWC. The general conclusions of the evaluation are expected to run along the following lines:

- there is a continuing (and possibly expanding) need for the program and many of its sub-components (particularly laboratory services);
- program services, with some exceptions (e.g. epidemiological services) are deemed to be relevant to client needs and effective;
- the program mandate needs to be clarified, strengthened, and made more visible. Some concern is raised about organization and management of the program;
- responsibility (and resources) for the Quarantine Act should be transferred from Medical Services Branch to LCDC;
- the activity with respect to tobacco and alcohol should be limited to laboratory study and epidemiological surveillance, and that policy development activities in this area should be the responsibility of Policy, Planning and Information Branch; and
- the advisory committee structure be reviewed.

OBSERVATIONS

Statistics Canada (primarily the Health Status program but also the Health Care program) is a major source of data and information used by this program to carry out its disease surveillance activities. The program also collects its own data and prepares several statistical surveillance reports. Statistics Canada has the mandate and responsibility to collect and provide health data which the program can use in its epidemiological research. The relationship between the programs is seen as complementary. There does not appear to be any duplication in the collection of data from source. It is possible that Statistics Canada could assume all or part of the data collection for the program. The issues to consider would be:

- resource allocations between the two areas;
- effectiveness of resulting surveillance system;
- relative priority in Statistics Canada for new initiatives/changes.

There is no overlap or duplication within HWC between the program and the Information Systems Directorate, PPI Branch with respect to data collection.

The program has an extensive network of linkages with other programs at the provincial, national and international level that are indirectly or directly involved in disease control and surveillance.

The program's three advisory committees should be reviewed with respect to relevance, role, orientation and relationship to the formal federal/provincial advisory committee structure.

In the mid-1970's there was an attempt to shift production of reagents to the private sector but, because of the high cost, low volume nature of many reagents demanded, it was not attractive to the private sector. LCDC then resumed reagent production. Currently the LCDC uses two-thirds of the reagents produced and distributes the remainder upon request to other laboratories free of charge. However, some of the products and services that are by-products of the basic services of the program (e.g., reagents, proficiency surveys, etc.) could be considered as candidates for cost recovery.

Laboratory proficiency surveys designed to improve the accuracy and consistency of diagnosis among laboratories concerned with disease control are carried out by LCDC upon request, free of charge, subject to the availability of resources at LCDC.

Laboratory fume hoods for sale and in use in Canada are evaluated and certified free of charge, upon request from laboratories across Canada, by LCDC in accordance with safety standards established by LCDC.

The laboratory services appear to be very well received by clientele in terms of relevance, need and effectiveness of services. The epidemiological services appear to be less well received although the clientele maintain there is a need for the service. This dissatisfaction can be linked to a lack of clarity and strength in the program's mandate in terms of leadership, support, and service roles. The evaluation report concluded:

- a leadership role may be seen in the development and application of new diagnostic methodologies, epidemiology and national surveillance and containment of diseases;
- a support role may be seen in the provision of reference, technical and epidemiology assistance to the provinces; and
- a service role (fee for) may be seen in proficiency testing, reagent production, and fume hoods.

OPTIONS

- Maintaining the National Health Surveillance program in its current organizational and functional form, subject to implementation of the recommendations made by the 1982 Auditor General's Report and the 1985 Program Evaluation Report and examination of a fee-for-service approach for laboratory proficiency testing, reagent production, and fume hoods;

- Establishing the Canadian Laboratory Centre for Disease Control as an arm's length agency. This option would allow for more independence with respect to mandate, priorities, management of resources and recovery of costs for services. At the moment, these issues do not appear to be sufficiently important from the perspective of beneficiaries to warrant the disruption of services such a transformation would cause;

- Transferring the current responsibilities of the LCDC to the provincial governments. The cost of decentralizing a reasonably well functioning central reference laboratory with highly specialized services outweighs the benefits, particularly in light of the level of satisfaction expressed by provincial clients.

The study team recommends to the Task Force that the government consider

- Maintaining the National Health Surveillance program in its current organizational and functional form, subject to implementation of the recommendations made by the 1982 and 1985 Auditor General's Reports, the 1985 Program Evaluation Report and examination of a fee for service approach for laboratory proficiency testing, reagent production and fume hoods.

HEALTH RESEARCH

Overview

Programs

Health and Welfare Canada funds two health research grant programs through:

a. National Health Research and Development Program - a branch within Health and Welfare Canada.
b. Medical Research Council - a Crown corporation operating under the Medical Research Council Act.

Observations

Each program uses peer review mechanisms to ensure the quality of the projects funded.

MRC funds basic and clinical research and NHRDP funds applied research. Priorities for NHRDP research are set by HWC.

The $160 million annual funding by MRC is approximately 50% of the funding for medical research in Canada.

Both programs fund research scientists and research fellows in order to develop and train research personnel.

Options

The study team recommends to the Task Force that the government consider:

-maintaining funds for both programs on the same basis and with the same organization as at present.
-increasing funds for both programs gradually, based on plans of about five years duration.

MEDICAL RESEARCH COUNCIL

OBJECTIVES

To provide support for medical research and for those interested and involved in medical research so as to assist in the provision of a research community and to maintain activity of a scale and quality appropriate to the Canadian research community.

BENEFICIARIES

Health science centres across Canada; health science researchers and students; and indirectly, the Canadian public.

AUTHORITY

The Medical Research Council Act, M-9.

RESOURCES ($000's) and (P-Ys)

Expenditure	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Actual	86/87 Projected
Salaries	$1,423	$1,980	$2,232	$2,275	$2,365
Operating	959	929	1,314	1,209	1,284
Capital	15	** 217	63	13	13
Grants and Contributions	110,908	137,313	153,191	157,986	127,100
TOTAL	$113,305	140,439	156,800	161,483	130,762
Person-years	42	50	54	54	54

Data supplied by HWC.

** Acquisition of computerized tracking system of applications and grants.

DESCRIPTION

The Medical Research Council (MRC) is a crown corporation which reports to the Minister of Health and Welfare Canada on its activities and the state of health research in Canada.

The Council has a full time president who is Chief Executive Officer and 21 other members representing the scientific and lay community who serve without remuneration. Membership on the Council also includes three associate members who represent the other two federal granting agencies and HWC.

-MRC funds research activities through:
-grants programs - operating, major equipment and maintenance grants;
-personnel support programs - salary support and research training; and
-travel and exchange programs.

Funding awards are based on peer review. This consists of 23 grant and six award committees with a total of over 250 working scientists. MRC also uses external references from Canada and other countries.

Primary orientation is towards health science faculties, dental schools and pharmacy schools and thus, is to basic and clinical research.

Administration comprises a full-time president with 53 members of staff. Administration costs currently comprise 2.7% of total budget.

MRC attempts to operate a five-year plan to provide funding stability for projects and individuals.

In 1984/85 MRC funded 3,767 projects of which 1,415 were continuing, 996 were renewals and 1,356 were new.

EVALUATION

No formal program evaluation has been performed in the past five years.

OBSERVATIONS

MRC research funding is the single most important source for basic and clinical medical research in Canada, comprising approximately 50% of available research monies.

MRC's focus has been and continues to be on the basic and clinical medical sciences. Some discussion of "applied" research (epidemiology, etc.) has taken place at the Council in recent years but no significant funding to "applied" research has been given. Applied research is funded through the National Health Research and Development Program (NHRDP).

The issues of growing competition for funds (MRC funds about 30% of applications), research ethics, research evaluation, etc. create an increasing administrative requirement.

MRC is held in high regard by the Canadian research community and has served the national public interest well.

It is estimated that, because researchers obtain additional funds from other sources as well, MRC grants give access to about $2 worth of research and development for each $1 granted.

It has been suggested by some that the mandate of MRC should be widened to include all health related research. While tidier arrangements appear to contribute to more efficient administration, the benefits of effective research may be lost in the process.

OPTIONS

The study team recommends to the Task Force that the government consider maintaining the status quo, with careful attention to ensuring the funding stability required for the research community and evidenced by the five-year planning objective.

Discussions between MRC and NHRDP (and other federal councils in regard to their health research) should be conducted on a regular basis to ensure that actions are complementary. While, ultimately, integration may be of benefit, and provide some cost saving opportunity, the "applied" health research "industry" may not yet be sufficiently organized to ensure that its own funds do not find their way into basic and clinical medical research.

NATIONAL HEALTH RESEARCH AND DEVELOPMENT PROGRAM (NHRDP)

OBJECTIVE

To provide support for scientific activities designed to yield information (i.e., new knowledge) needed by the Department of Health and Welfare Canada (HWC) to help fulfill its responsibilities to the people of Canada.

BENEFICIARIES

HWC - Health Protection Branch
- Medical Services Branch
- Health Services and Promotion Branch

Applied health care researchers,
e.g., epidemiologists
Provinces

AUTHORITY

S.5(b) Department of National Health and Welfare Act.

RESOURCES ($000's) and (P-Ys)

Expenditure	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Estimate	86/87 Projected
Salaries	738	719	835	830	830
Operating	294	230	320	302	302
Grants and Contributions	14,092	16,044	18,123	19,309	19,309
TOTAL	15,124	16,993	19,278	20,441	20,441
Person-years	18	19	21	19	19

Data supplied by HWC

DESCRIPTION

NHRDP supports research projects/studies (80% of grants) and individual researchers (20% of grants).

Research projects/studies include original projects, both research and demonstration, studies of data, preliminary development projects, symposia and conferences and formulation funding for good ideas where a proposer lacks research expertise.

Support of individual researchers is through Training and Career Awards programs.

Research proposals are reviewed first for eligibility under NHRDP terms of reference, secondly by HWC Branches and by the province for relevancy and finally by a peer review mechanism. Approval is needed at all three levels for success.

The projects are reviewed annually and continued funding depends on satisfactory progress.

80% of grants are to university projects/researchers and 20% to non-university. NHRDP is the only significant agency in Canada making funds available to the latter area.

Current priorities are research into

- Organization and delivery of health care
- Environmental health hazards
- Primary and secondary illness prevention
- Habilitation and rehabilitation
- Health of native people.

About 775 submissions were received in 1984/85.

384 research projects, 153 scholars and 26 conferences were supported for a total of 563 awards.

EVALUATION

Departmental evaluation was done in November of 1984 with recommendations that:

- there be a HWC mechanism for the periodic articulation of its own research priorities;
- there be a periodic needs assessment within departmental priorities of the types of research to be undertaken;
- there be improved data maintenance and updating; and
- there be improved dissemination of information.

OBSERVATIONS

NHRDP represents the single most significant source of encouragement to researchers interested in examining areas other than basic and clinical medical research.

The requirement that relevancy to HWC Branch objectives be satisfied has the potential to unduly constrain applied research, although evidence that such is the case is not apparent.

Administration is experienced, competent and lean.

Networking with other agencies involved in research appears to be good.

Current funding levels are said to create 3,000 research positions in whole or in part.

It appears that some HWC funding of research is done by the three beneficiary branches outside the NHRDP framework.

Some provinces and others commented that the communication of research results to organizations that can use them is lacking. This is a problem in all research organizations; NHRDP was well aware of this deficiency and is looking for ways to improve.

OPTIONS

Organization

Continue to make NHRDP responsible for all HWC health related research funding.

Set up NHRDP as separate and distinct council (along lines of MRC).

Funding

Continue the past trend of funding increases.

Freeze funding at current levels.

Reduce Funding.

The study team recommends to the Task Force that the government consider allowing NHRDP to continue to be responsible for all NHW research funding and further that the past trend of funding increases be continued.

While setting up a separate and distinct council has some attraction to highlight non-directed support for applied research, the increase in administrative cost which would result is greater than the perceptual benefit to be derived. If NHW is to fund health and health care research, it should be under the scientific and administrative control of a single program; NHRDP is the natural choice.

With respect to funding levels it is unlikely that the applied research community could either absorb faster rates of increase or tolerate reductions. In our view, the funding to this area should continue to increase as it offers the potential for improving health care delivery in the longer run and is the single significant source of funding for this type of research.

HEALTH PROMOTION AND FITNESS

Overview

Programs

The family of programs concerned with the promotion of a healthy lifestyle includes:

Health Promotion
Fitness Canada

Health Promotion is a program located in the Health Services and Promotion Branch of Health and Welfare Canada. Fitness Canada is a program located in the Fitness and Amateur Sport Branch of Health and Welfare Canada.

Assessment

Both Health Promotion and Fitness Canada have similar objectives and subscribe to the World Health Organization's definition of health as "physical, mental and social well-being". However, there are few linkages between them. Fitness Canada does not participate in any health promotion planning committees and, with the exception of a new group examining weight control, Fitness Canada is not involved in health promotion strategy development. In addition, the contributions programs for both directorates function somewhat differently.

There is, with a few exceptions, fairly favourable support for the two main issues in this family of health services. They are: coordination of fitness and health promotion subject areas, and the extension of these program areas into some type of arm's-length organization.

If coordination of the two programs is to be considered then it is important, in the view of the study team, that the distinctive fitness message, and the high program profile provided by the Minister not be lost.

If an arm's-length organization is to be considered for the activities associated with health promotion and fitness then it is important that all national concerns are addressed, and that there is corporate compatibility with the message being delivered. The organization would have to be responsible not only for advertising and programming.

Given the success of PARTICIPaction, it could be considered as the promotion and advertising mechanism for such an organization.

Any integration of fitness and health promotion activities into one unit should take into consideration the fact that Fitness Canada has a nationally recognized identity and that the visibility provided by the Minister of Fitness and Amateur Sport has been valuable. It is also important that the delicate working relationship with the provinces should not be disrupted.

Options

The study team recommends to the Task Force that the government consider integrating Health Promotion Directorate and Fitness Canada within an arm's-length corporation which would market concepts and programs within the mandate of the integrated directorates. Given the high visibility and success of PARTICIPaction, it should be encouraged to link with the new corporation through an interlocking board structure.

HEALTH PROMOTION
HEALTH AND WELFARE CANADA

OBJECTIVE

To help Canadians achieve healthy life styles.

BENEFICIARIES

The general public who are reached with advertising, promotional materials and information provided in a variety of ways.

Professionals and volunteers in the health care delivery systems.

Private business whose involvement is sought as a means of delivering health promotion messages or as centres for health promotion programs (e.g. Corporate Challenge).

AUTHORITY

In 1978 Health and Welfare Canada (HWC) established the Health Promotion Directorate to give greater emphasis to its preventive health programs. This program was a direct outgrowth of the 1974 working document entitled "A New Perspective" which committed the department to push ahead with its recommendations.

In 1982/83 a submission was presented to Cabinet which extended the mandate to 1988/89. At this time a report must be submitted that indicates progress made and recommendation for mandate change or approval.

RESOURCES ($000's) and (P-Ys)

Expenditure	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Estimate	86/87 Projected
Salaries	3,561	4,257	4,481	4,763	4,763
Operating	6,263	6,813	7,033	7,486	7,486
Capital	60	43	106	-	-
Contributions	3,668	3,944	3,650	4,240	4,240
TOTAL	13,552	15,057	15,270	16,489	16,489
Person-years	116	109	112	113	113

Data supplied by HWC

DESCRIPTION

Four strategies have been used by the Directorate:

Equipping the public to deal with lifestyle issues. This encompasses the informational activities of the program.

Promoting a social climate that supports healthy lifestyles. This encompasses the advertising and promotional work that is done. It also offers a mandate to counteract negative influences such as aggressive marketing of tobacco and alcohol.

Supporting self-help and citizen participation in health promotion. This involves joint projects with voluntary organizations, production of program materials for use by citizen groups, and providing funds with which they can do their work.

Promoting the involvement of health care, social welfare, and other established programs in health promotion. The purpose of this strategy is to shift the health system more in the direction of prevention. It is carried out through cooperative planning with provincial departments of health, joint projects with organizations of health professionals, preparation of program materials for their use, and some funding of demonstration projects.

The Health Promotion program is divided into 12 components for purposes of planning, management, and delivery. Of this number:

five components address lifestyle issues, notably nutrition, smoking, alcohol use, drug use and hypertension;

four components address the concerns of particular population groups, namely, children and youth, women, the elderly, and the disabled; and

three components address functions or methods of delivery that are central to health promotion, that is, communications, school health and health promotion in the workplace.

The work of the Health Promotion Directorate is done in two ways:

operational activities performed by the department directly or under contract; and

contributions offered to voluntary and professional groups who wish to be active in health promotion.

Direct communication with the public is achieved through media advertising, promotional activities, and distribution of information. The most significant advertising programs are Generation of Non-Smokers, Dialogue on Drinking, and Stay Real, a cannabis information project. During the 1984/85 fiscal year, 7.5 million pieces of information material were distributed to the public.

The means used to encourage more active participation in health promotion on the part of provinces, groups of health professionals and voluntary associations are varied. They include:

joint planning ventures;

major projects undertaken on a shared cost and time basis;

provision of program materials;

expert consultation; and

contributions funding.

EVALUATION

An evaluation of the program is scheduled for 1987 in preparation for the report to Cabinet.

OBSERVATIONS

Health promotion activities are also a provincial activity and responsibility so that there needs to be close consultation between federal and provincial governments.

There is no objective proof that the present method for delivery of health promotion is or is not successful, although there is a developing science of evaluation in the field of health promotion.

The present method for delivering health promotion is labour intensive, i.e. 113 person-years.

Health Promotion, i.e. government, is not able to tap the corporate sector for financial support of programs.

Government health promotion operations in their present mode may be more effective if a corporate model similar to PARTICIPaction were considered.

PARTICIPaction is an excellent marketing model for the delivery of health promotion information with government input and the ability to draw on the corporate sector for financial support.

Although PARTICIPaction deals only with the positive aspects of health promotion, i.e. fitness, and does not deal with the same range or scope as Health Promotion, to our knowledge there is no evidence to suggest that the negative aspects of health promotion, e.g. the battle against drug and alcohol abuse, can not be sold to the private sector as well as the public sector if marketed correctly.

However, arm's-length corporations such as PARTICIPaction diminish government's ability to ensure that programs are consistent with government policy.

Fitness Canada and Health Promotion have program objectives that tend to overlap. In fact, Fitness Canada's definition of fitness as "physical, mental and social well-being" is the same as the World Health Organization's definition of health.

Physical activity, the cornerstone of Fitness Canada, is also an integral part of strategies used by Health Promotion. Examples of this overlap include:

- the use of physical activity as an essential component of any program to prevent chronic illness, particularly cardiovascular disease;
- programs to reduce smoking, improve nutrition and increase activity have been shown to have a synergistic effect;
- weight management is most effectively achieved by diet and exercise; and
- recreation is one of the cornerstones of mental health.

All of the above are emphasized by both Fitness Canada and Health Promotion. Health information is required by fitness and recreation leaders if they are going to carry out their responsibilities effectively.

There is a delivery system that exists in every community throughout the country for fitness and recreation.

Fitness in the workplace is an important aspect of Fitness Canada, and Health Promotion has overlapped with its Corporate Challenge program.

Should the integration of Fitness Canada and Health Promotion take place, the following points should be considered:

- the national identity for fitness that has been developed by Fitness Canada should not be lost;
- the visibility provided by the Minister of Fitness and Amateur Sport is valuable in the promotion of fitness and should not be lost;
- provinces should be consulted so that working relationships are not disrupted; and
- in the production of promotion material, present health care delivery system professionals should be included as one of several strategies for information dissemination.

OPTIONS

Integrating Health Promotion Directorate and Fitness Canada within an arm's-length corporation which would market concepts and programs within the mandate of the integrated directorates. Given the high visibility and success of PARTICIPaction, it should be encouraged to link with the new corporation through an interlocking board structure;

Combining Fitness Canada and Health Promotion;

Maintaining the status quo.

The study team recommends to the Task Force that the government consider integrating the Health Promotion Directorate and Fitness Canada within an arm's-length corporation which would market concepts and programs within the mandate of the integrated directorates. Given the high visibility and success of PARTICIPaction, it should be encouraged to link with the new corporation through an interlocking board structure.

APPENDIX ONE

HEALTH PROMOTION - FITNESS

"ARM'S-LENGTH" CORPORATE STRUCTURE

A suggested outline of the elements relating to an "arm's length" corporate structure which would accommodate the activities of the Health Promotion Directorate and the Fitness Canada Directorate follows:

Mandate	Set by the Minister of Health and Welfare Canada and the Minister of State for Fitness and Amateur Sport in consultation with provincial health ministers.
Board	Membership: To be determined by the Minister of Health and Welfare Canada - taking into consideration an appropriate mix of federal, provincial and private sector representation. Purpose: To determine the ability of this "arm's-length organization" to become more self-supporting with less demand on government for financial support.
Activities	Production Marketing Sales Research/Development Admin/Support Consultation Screening and awarding of grants to community groups etc. in keeping with objectives of corporation
Timeframe	a. Establish within one year b. Five-year evaluation after which decision to continue or disband

Linkage with PARTICIPaction

a. Interlocking board of directors
b. Clarification and agreement on mandates

FITNESS CANADA
FITNESS AND AMATEUR SPORT CANADA

OBJECTIVES

To raise the fitness level of Canadians through increased participation in physical activity thereby contributing to health, well-being and the capacity to perform daily activities.

BENEFICIARIES

- Major national associations and special target group organizations involved in fitness
- Universities conducting fitness related research
- Arm's-length corporations providing services related to fitness.

AUTHORITY

The Fitness and Amateur Sport Act, (1961) provides a general mandate to encourage, promote and develop fitness in Canada. In 1981, Cabinet approved a major policy focus:

> to improve the general environment, organization infrastructure and program delivery systems for physical activity throughout Canada;
>
> to increase the motivation of Canadians to engage in physical activity; and
>
> to increase the availability and accessibility of quality programs which facilitate participation in physical activity.

RESOURCES ($000's) and (P-Ys)

Expenditure*	**82/83** Actual	**83/84** Actual	**84/85** Actual	**85/86** Estimate	**86/87** Projected
Salaries	769	779	788	839	839
O&M	521**	311	335	351	351
Capital	1	1	5		
Contributions	6,407	7,148	7,787	8,339	8,339
TOTAL	7,698	8,239	8,915	9,529	9,529
Person-years	24	24	24	24	24

* FAS Financial Planning, Management & Services Directorate

** Includes one-time-only item for a National Conference on Fitness and Aging of $139,300.

DESCRIPTION

By its promotion of physical activity through financial contributions and consultative services, Fitness Canada works to develop fitness leadership nation-wide and to encourage participation in physical activity leading toward fitness of all Canadians. In addition, it has identified specific target groups for special emphasis.

Major activities are grouped under four areas of fitness development: Promotion, Education, Leadership Development and Research.

Promotion

Fitness Canada has undertaken a major commitment to the national promotion of fitness as evidenced by the formation of PARTICIPaction in 1971. With ongoing financial support from Fitness Canada ($1,016,000 in 1985/86 to date) the PARTICIPaction promotional campaign works to increase Canadians' awareness of the benefits of fitness and encourages them to aim for higher rates of participation in physical activity.

Fitness Canada also supports opportunities for general participation in physical activity. On this basis, financial assistance has been provided for a number of participation development projects run by national associations. In addition, Fitness Canada has developed and currently operates National Physical Activity Week in cooperation with a number of national organizations and provincial governments. This major initiative strives to raise the general awareness of the benefits of physical activity.

The Canada Fitness Award serves as an incentive for Canadian youth by promoting increased standards of achievement and thereby encouraging regular physical activity leading toward fitness.

Education

Fitness Canada has also initiated and supported a number of educational activities which are designed to upgrade the knowledge of both the consumer and those individuals involved in the development of physical activity and fitness programs. Fitness Canada distributes approximately one million pieces of literature annually. In addition, financial support has been provided to a number of national organizations for the design and production of resource material applicable to the needs of specific target populations.

Leadership Development

A major objective of Fitness Canada is to improve the delivery system in Canada of opportunities for participation in physical activity. One of the principal methods of accomplishing this objective is through the development of a strong base of capable leaders, volunteers and professional staff working at the local, provincial and national levels.

In cooperation with the Interprovincial Sport and Recreation Council and a number of national associations, guidelines and resources for the training of fitness leaders have been developed. By means of financial support from Fitness Canada, the Fitness Appraisal Certification and Accreditation Program operates across Canada through the Canadian Association of Sport Sciences. This program is designed to provide Canadian consumers with reliable and safe fitness testing and appraisals.

In addition, the needs of individuals working in national fitness organizations have been addressed by Fitness Canada in conjunction with Sport Canada through the Skills Program for Management Volunteers and the Professional Development Practicum (PDP). While the PDP is strictly a national initiative, the Skills Program has been developed in cooperation with provincial governments and is currently being delivered by them or their affiliated agencies.

Research

Under the coordination and financial support of Fitness Canada, the Canada Fitness Survey Corporation was established and a national survey which included fitness testing was conducted in 1981. The Survey has grown steadily as a recognized source of information on Canada's participation patterns in physical activity, as well as national physical fitness levels. This information is being continually analyzed, "packaged" in a number of publications and made available to researchers, organizations and program leaders working in the field of physical activity and fitness.

Fitness Canada has also operated a special research contribution program since 1980.

Fitness Canada believes that there is a clear need to define Canadian priorities as well as develop a national framework for fitness which will assist in the coordination of programs and activities at the national, provincial and local levels. This coordinated approach was initiated in May 1985, with the first Federal/Provincial Ministers' Conference on Fitness. The Conference resulted in the formation of a number of federal/provincial working committees set up to investigate mechanisms of collaborative program design and delivery, for example - Fitness In the Workplace, National Physical Activity Week, Fitness and the Third Age. In addition, a National Summit on Fitness was announced and is currently scheduled for early in the 1986/87 fiscal year.

Although PARTICIPaction is an extension of the Fitness Canada program, it is legally and organizationally distinct. The corporation was launched by Fitness and Amateur Sport (FAS) in 1971 as an arm's-length, non-profit company whose mandate was to use the mass media to change Canadians' attitudes and values about fitness. The initial federal government investment was $250,000 which was the only revenue available to PARTICIPaction at that time. In 1985 the total annual operating budget is estimated at $2.5 million with just over $1 million coming from the contributions budget of Fitness Canada. The non-government revenue is generated from services that PARTICIPaction renders to business organizations and provincial governments. The corporation, which describes itself as a private, non-profit, national communications company, has a volunteer Board of Directors on which are included the Assistant Deputy Minister of FAS plus two appointees of the Minister of FAS. There is a staff of 22 working out of the main office in Toronto and a smaller office in Montreal.

To achieve its goal of encouraging Canadians to become more physically active, PARTICIPaction does three things:

- creates public service advertising in all media;
- develops and sells fitness education materials; and
- devises sponsored fitness promotion with specific corporations and government groups.

The activities associated with the advertising function are funded solely by Fitness Canada. In 1984/85 this amounted to $548,000 from which PARTICIPaction claims approximately $14 million worth of advertising donated by the media. Thus, without having paid a penny to actually purchase media time and space, PARTICIPaction has become one of the largest, most influential communications companies in Canada by generating millions of dollars of free exposure for fitness promotion annually.

In addition to its advertising, the company plans, designs and executes various types of health and fitness promotion campaigns for corporate or governmental sponsors. These campaigns collectively reach millions of Canadians through a large distribution system composed of fitness and nutrition leaders, educators, researchers and health professionals who have paid for a membership in the PARTICIPaction Network.

EVALUATION

There has been no formal program evaluation of Fitness Canada in the last five years.

OBSERVATIONS

The program's legislative mandate is very broad and has allowed expansion in any direction that the Minister of the day believed was necessary. It is difficult to derive jurisdictional authority or specific program objectives from the 1961 FAS Act which does not even define reporting relationships or functional responsibilities. The original involvement of the National Advisory Council of Fitness and Amateur Sport (established by the Act) in policy decision-making and the approval of grants has been eliminated over time due to the creation of the Fitness Canada Directorate and its assumption of all program responsibilities.

The directorate appears to be taking a progressively more pro-active role in the coordination of fitness activities at the national level.

Fitness Canada's programs in areas such as standardized tests of fitness, National Physical Activity Week, the Canada Fitness survey, and fitness leadership development are well respected by professionals in the field both in Canada and abroad.

Although Fitness Canada was instrumental in setting up PARTICIPaction and continues to provide all the funding necessary for its advertising program, there appears to be some duplication of effort in the promotion and marketing of fitness between the two organizations.

Approximately 60% of the directorate's contributions budget is spent on promotion related activities but there is little hard evidence of cost-effectiveness (other than the 1982 study which showed that over the preceding 10 years, there had been a significant increase in the percentage of adult Canadians committed to a physically active lifestyle. For 85% of the people interviewed for that study, PARTICIPaction appeared to have played the major role in bringing about this change).

There is a perception that the urgency of many of the Sport Canada initiatives deprives Fitness Canada of the attention it deserves. Currently, Fitness Canada has a significantly lower contribution budget (approximately $8 million) than Sport Canada (approximately $44 million). It is of interest to note that relative to Health Promotion, Fitness Canada has double the contributions budget but fewer than a quarter of the related person-years.

The respective roles of Sport Canada and Fitness Canada regarding competitive sport require clarification. Sport Canada views its jurisdiction as governing all aspects of sport, with the High Performance area simply a component of a multilayered domestic sport system. Fitness Canada, on the other hand, wishes to incorporate the skill development layer of sport into its mandate.

Many of the national organizations receive funding from both Fitness Canada and Sport Canada. This has resulted in funding inconsistencies within FAS and differences in accountability requirements within the organizations receiving contributions.

Fitness Canada, PARTICIPaction and the Health Promotion Directorate of Health and Welfare Canada all have their own delivery mechanisms for promoting their messages, distributing their materials, and providing their services. In the study team's opinion, there appears to have been limited cooperative effort to integrate these networks.

There is duplication of program focus in Fitness Canada with the Corporate Challenge initiative of the Health Promotion Directorate. The question arises as to where such an activity would most appropriately be housed.

In fact, there does not seem to be a logical reason why Fitness and Health Promotion are separated. They appear to have the same objective. Combining them might result in a more integrated national health promotion strategy although the risk of losing the momentum of fitness promotion (which is currently very strong) and a possible loss of visibility in the fitness area will need to be considered.

On the other hand, Fitness Canada does benefit from its location in FAS with its closer links to the Minister, the relative speed with which decisions can be made and implemented, and the absence of numerous other programs competing for diminishing resources. With the comparative vulnerability of the Health Promotion Directorate as a "soft" program in Health and Welfare, any integration of Fitness Canada into that program could run the risk of seriously jeopardizing its identity.

OPTIONS

- integrating fitness and the health promotion area and create an arm's-length corporation which would market concepts and programs currently within the mandate of Fitness Canada and the Health Promotion Directorate. Given the present high visibility and success of PARTICIPaction, it should be encouraged to link with the new corporation through an interlocking board structure (see Health Promotion chapter);

- integrating Fitness Canada and Health Promotion Directorate but with careful planning of the manner in which this is undertaken to avoid damaging the current relationships with the provinces, national agencies, and professionals in the health care delivery system. PARTICIPaction should be asked to play a lead role as the promotion mechanism of the integrated agency to promote its programs and priorities in cooperation with the provinces.

-maintaining the Fitness Canada Directorate within FAS but integrating the Corporate Challenge program from Health Promotion. PARTICIPaction should be asked to assume responsibility for the promotional role currently played by Fitness Canada;

The study team recommends to the Task Force that the government consider

-integrating Fitness Canada and the Health Promotion Directorate within an arm's-length corporation which would market concepts and programs within the mandate of the integrated directorates as soon as feasible. Given the present high visibility and success of PARTICIPaction, it should be encouraged to link with the new corporation through an interlocking board structure.

-Repealing or amending the Fitness and Amateur Sport Act.

By April 1, 1986, a mechanism should be developed and implemented to ensure that there is no duplication of funding for the same purpose to national organizations by both Fitness Canada and Sport Canada.

HEALTH SERVICES

Overview

Programs

The only program that relates directly to the area of federal coordination is the Health Services Directorate in the Health Services and Promotion Branch of Health and Welfare Canada.

Observations

The principle function of the Health Services Directorate is to provide leadership and coordination in the area of federal/provincial consultation and collaboration and this accounts for roughly 70% of its resources (directly and indirectly). As of 1985, there are some 70 federal/provincial committees of various types supporting the Conference of Deputy Ministers.

A secondary function of the Directorate is in providing executive support, advice and guidance to the federal Minister in the various health service areas. This function requires re-evaluation to determine exactly what advice is required and what is the best method of providing that advice.

Options

The study team recommends to the Task Force that the government consider:

- evaluating the role of the Health Services Directorate in light of federal government's need for advice and executive support and the need for consultation with provinces regarding health issues.
- placing a moratorium on all Federal/Provincial Advisory Committee meetings and sub-committee meetings and working groups effective April 1, 1986, subject to a critical review of on-going necessity and mandate by the Deputy Ministers' Conference.
- determining what advisory resources (expertise) HWC requires and in what areas to provide federal ministerial and executive support.

-developing jointly, by the Deputy Minister of HWC and Provincial Deputy Ministers of Health, an appropriate mechanism for consultation services;
-assessing the human resources required by Health and Welfare Canada, once level of consultation and executive support has been determined;
-accomplishing the last three suggestions by September 1, 1986.

HEALTH SERVICES
HEALTH AND WELFARE CANADA

OBJECTIVES

To provide leadership and coordination in assisting the provinces and territories to bring their health services to, and maintain them at, national standards.

BENEFICIARIES

The primary mandate of the Health Services Directorate is in the area of direct contact with:

Provincial departments of health.

National voluntary associations such as Canadian Mental Health Association.

National professional organizations such as Canadian Medical Association.

National and international organizations such as Canadian Hospital Association and the World Health Organization.

AUTHORITY

There is no specific legislative authority for the Health Services Directorate. The National Health and Welfare Act, section 5, provides a general mandate and specifies, among other things:

investigation and research into public health and welfare;

investigation and research into the collection, publication and distribution of information relating to the public health; and

cooperation with provincial authorities with a view to the coordination of efforts made or proposed for preserving and improving the public health.

Health Facilities Design division was created by a 1945 Order-in-Council.

RESOURCES ($000s and P-Ys)

Expenditure by Budget Element

Expenditure	**82/83 Actual**	**83/84 Actual**	**84/85 Actual**	**85/86 Estimate**	**86/87 Projected**
Salaries	3,251	3,559	3,667	3,739	3,666
Operating	1,798	2,104	2,324	2,780	2,580
Capital	24	38	89	-	-
Grants and Contributions					
Family Planning	1,100	174	174		
Nat'l VOL Health Organizations	441	2,793	3,015	3,176	3,249
UBC Diagnostic Imagery Centre		1,000			
Univ. of Ottawa Heart Institute			2,500		
Summer Canada	10				
Sub-Total Grants	1,541	3,977	5,689	3,176	3,249
TOTAL	6,614	9,678	11,769	9,695	9,495
Person-years	72	72	75	73	71

Data supplied by HWC.

DESCRIPTION

This program includes six separate sub-programs namely:

-Mental Health;
-Community Health;
-Health Assessment;
-Institutional and Professional Services;
-Health Facilities Design; and
-Health Manpower;
-Canadian Blood Committee.

In addition the program management unit consists of:

-Director General Health Services;
-Senior Consultants (2); and
-Program Coordinator.

The primary focus of the Health Services Directorate is to promote the continuing development and maintenance of reasonable standards of health care and parity among provincial health programs.

The Directorate assists the provinces by playing a leadership and coordinating function. This leadership and coordinating function is through the Federal/Provincial Advisory Committee structure that was established to assist the Conference of Deputy Ministers in fulfilling its mandate. It provides a mechanism for federal/provincial consultation and collaboration at the officials level. As of 1985 there are some 70 federal/provincial committees of various types supporting the Conferences of DM's.

Following is a description of each sub-program.

Mental Health ($000s) and (P-Ys)

	82/83	83/84	84/85	85/86	86/87
Expenditure	682	780	960	1,001	1,101
Person-years	10	11	12	10	10

The purpose of this activity is:

> To facilitate the exchange of information that will assist in improving the quality of mental health across Canada and share experiences from different parts of the country. The primary audiences are the provinces and professionals in the field.

This is accomplished by:

- publishing a quality journal on mental health;
- publishing various booklets on mental health;
- organizing meetings, symposia and conferences that deal with the major mental health issues of the day; and

- stimulating research and developing, promoting and seeking consensus on strategies for more effective ways of delivering mental health services.

Community Health ($000s) and (P-Ys)

	82/83	83/84	84/85	85/86	86/87
Expenditure	955	3,452	3,622	3,898	3,998
Person-years	9	9	10	9	9

The purpose of this activity is:

- to provide support and assistance to the Federal/Provincial Advisory Committee on Community Health in such areas as accreditation of public health units, home care and community health information systems;
- to provide funding for administrative support to about 50 national voluntary health organizations, a total of $3.1 million;
- to provide consultation to other federal departments, such as participating with the Department of Veterans' Affairs and Ste Anne's Hospital in Montreal, to determine the feasibility of making it into a national centre for care and treatment of the elderly;
- to provide consultation to the voluntary sector such as participating in the planning of an international conference with the Canadian Council on Rehabilitation to be held in Vancouver. Staff have assumed a major leadership role in this activity; and
- to provide consultation to international organizations such as the World Health Organization e.g. in the area of primary care. A representative of the federal government could be part of the delegation or head of the Canada delegation at the various WHO meetings.

Health Assessment ($000s) and (P-Ys)

	82/83	83/84	84/85	85/86	86/87
Expenditure	202	203	288	244	338
Person-years	3	3	4	3	3

The purpose of this activity is to work with the provinces and voluntary sector in finding ways and means to prevent and control chronic disease. Examples include:

- the development of a strategy and plan of action for the consideration of the Federal/Provincial Advisory Committee on Community Health;
- in cooperation with Saskatchewan, the University of Saskatchewan, Nova Scotia and Dalhousie University, the development and implementation of a comparative study on cardio-vascular disease; and
- a survey of serum lipid levels in the general public within the province of Nova Scotia.

Institutional and Professional Services
($000s) and (P-Ys)

	82/83	83/84	84/85	85/86	86/87
Expenditure	1,153	1,217	1,429	1,457	1,557
Person-years	13	12	12	13	13

The purpose of this program is to assist the provinces in maintaining and improving health care services to acceptable standards. In addition there is concern for:

- productivity through a major cost-sharing federal/provincial productivity improvement program that is specifically looking into staffing methodologies and work load measurement systems; and
- improvement of health services through the development of institutional guidelines with provinces as well as the development of clinical guidelines with professional groups.

Health Facilities Design ($000s) and P-Ys)

	82/83	83/84	84/85	85/86	86/87
Expenditure	1,130	1,186	1,215	1,363	1,363
Person-years	17	14	15	14	14

The purpose of this program is to work with the provinces to develop the standards and guidelines which they voluntarily implement in varying ways. Methodology used includes research, workshops, symposia and reports in such areas as energy and conservation, space programming and post occupancy evaluation. This program works within the federal/provincial advisory committee structure.

Health Manpower ($000s) and (P-Ys)

	82/83	83/84	84/85	85/86	86/87
Expenditure	304	312	263	323	323
Person-years	4	4	4	4	4

This program provides a technical support group to the Federal/Provincial Advisory Committee on Health Manpower and also acts as an information exchange unit. Provinces play a major role in this program that studies such issues as physician manpower in Canada, producing a series of reports on the issue.

Director General ($000s) and (P-Ys) (includes senior consultants and program coordinators)

	82/83	83/84	84/85	85/86	86/87
Expenditure	311	514	437	347	357
Person-years	5	8	5	5	5

The major purpose of the program management area is to act as an administrative facilitator, to provide secretariat services to various units and coordinate efforts as required. The main task of the Program Coordinator relates to central secretariat services for three federal/provincial advisory committees.

Canadian Blood Committee ($000s) and (P-Ys)

	82/83	83/84	84/85	85/86	86/87
Expenditure	152	150	305	368	368
Person-years	1	1	4	4	4

This committee was established in 1979 as a result of a decision by provincial Ministers of Health to coordinate activities relating to approval of budgets and programs for blood transfusion services operated by the Canadian Red Cross Society. The committee is responsible for approving annual budgets and new programs for the Red Cross as well as developing a National Blood Policy and monitoring the operation of the blood system to ensure it conforms with the established principles of voluntary donations, gratuity of blood and blood products, self-sufficiency and non-profit.

Provincial governments reimburse the federal government on a per capita basis for 50% of the costs of the committee.

EVALUATIONS

Presently there is a formal program evaluation being conducted by the Program Evaluation Directorate.

OBSERVATIONS

In discussions with program managers and in reviewing the various studies from within the Directorate, it was concluded that the program objectives seemed to be clearly understood by the staff. However, there was a lack of specific performance criteria by which the program would be evaluated.

The Directorate indicates that it exercises national leadership, coordination, information exchange, standards development and provides a federal presence thus contributing to improvements in the health care system. A constant concern of the Directorate is that they are "spreading staff too thinly over the various areas of responsibility". Yet without the stated measurement criteria it is impossible to determine whether the "areas of responsibility" are indeed necessary.

However, results of provincial visitation by the members of the Health and Sport Study Team do not fully reinforce the perceived role of the Health Services Directorate. Provincial comments extend along the continuum from "get rid of it" to "it is providing an essential service". The Maritime provinces and the territories in particular are positive towards the Directorate and feel that it is providing useful services that should not be eliminated. Others indicate that the program could be abolished although there is recognition that the various advisory committees do have a role to play and that the committees provide the provinces with opportunities for collaboration leading to common positions. However, if eliminated, the provinces would replace it with something on their own. All provinces commented that the Deputy Ministers Conference is not functioning as an effective consultative mechanism and is not providing the leadership and guidance to the Advisory Committee structure that is required, if that structure is to provide a useful and meaningful mechanism for consultation.

It has also been stated that in order for the federal minister to receive knowledgeable advice and guidance in the various health service areas, involvement and participation by Directorate staff are essential. However, there may be alternate methods and different sources of expertise that the minister could call upon to obtain the required information. There is also no certainty that the various guidelines, studies, publications, pamphlets, reports are essential to the improvement of the health care system. Can these tasks be done more economically and effectively by others?

OPTIONS

In view of all this, the study team recommends to the Task Force that the government consider the following:

- evaluating the role of the Health Services Directorate in light of the federal government's own need for advice and executive support and the need at both levels of government for consultation (i.e., support to the federal/provincial advisory committee structure) regarding health issues;
- placing a moratorium on all federal/provincial Advisory Committee and sub-committee meetings and working groups effective April 1, 1986, subject to a critical review of ongoing necessity and mandate by the Deputy Ministers of Health Conference;
- having the department determine by September 1, 1986 what advisory resources (expertise) it requires and in what areas to provide federal ministerial and executive support;

-having the Deputy Minister of National Health and Welfare meet with provincial Deputy Ministers of Health before September 1, 1986, to develop an appropriate mechanism for consultation services.

Once the level of consultation and executive support been has determined, the human resources required by Health and Welfare should be assessed.

SPORT

Overview

Programs

The family of programs connected with sport includes:

-Sport Canada; and
-International Sports Relations.

Sport Canada is located in the Fitness and Amateur Sport Branch in Health and Welfare Canada. International Sports Relations is under the Cultural Policy Division, Social Affairs Branch of External Affairs.

Observations

Within the quadrennial sport cycle there is an increasing number of events both in Canada and abroad in which Canadian teams and athletes must participate to be competitive against the top ranking nations in the Olympic Games and world championships. This fact has stimulated the growth of a much more complex athlete development program which has needed centralized coordination and leadership. The federal government has been providing the planning framework, financial support and international liaison required to pursue the goal of excellence in international amateur sport. The issue now is whether the present infrastructure of sport can sustain itself sufficiently well without as much direct government involvement. Given the current administrative and financial status of many national sports organizations, and the agencies serving their needs, sudden withdrawal of government support would seriously affect the viability of their programs. On the other hand, the virtual guarantee of annual funds from government seems to have reduced the pressure felt by these organizations to seek additional or alternative sources of financial support.

There seems to be general acknowledgement that greater effort should be expended on persuading the corporate sector to view amateur sport as a worthwhile investment. However, many of the programs that are an integral part of an athlete's training regime (e.g., coaching certification, sports medicine) would be of little commercial interest to corporations and their costs would probably have to be assumed to a far greater extent by participants.

Sport Canada currently requires national sports governing bodies to meet certain planning criteria before their contribution applications will be approved. The intent is to develop the administrative and technical expertise of the organizations and to ensure the coordination of the numerous support activities (high performance sport centres, sports medicine, coaching programs) which prepare athletes for success in major international sports events. Presumably, if such planning achieves the desired objective over time, the program and service role of Sport Canada would diminish significantly. The need of the sports organizations for a range of sources of financial support will, however, remain.

The success of Canadian athletes in recent international competition suggests that there has been a demonstrable "pay-off" for the federal investment in "Best Ever" programs designed to achieve the federal objective of Canada ranking high in world standings. A decision to raise, maintain, or lower Canada's ranking objectives in sport would be a political one, with associated resource implications. Since Sport Canada's role and resource needs have been significantly affected by the emphasis on high performance sport and the commitment to the quadrennial sport cycle, such political decisions would presumably determine the level of service that would be authorized for the program.

To date, the use of sport as an adjunct to various international activities or as a manifestation of social policy abroad appears to be under-exploited. There will always be a need to utilize the services of External Affairs when negotiating bilateral sports agreements or making bids for major games such as the Olympics. However, it would seem worthwhile to explore further the potential of sport as a vehicle for increasing Canada's profile abroad.

Options

The study team recommends to the Task Force that the government consider phasing down the program over a 10-15 year period to give the high performance athlete development system some time to seek and establish sufficient viability, both organizationally and financially, to operate relatively independent of government.

Prior to the onset of the next quadrennial sport cycle, assess the issue of performance ranking being linked to the level of funding authorized for Sport Canada.

SPORT CANADA

OBJECTIVES

To provide leadership, policy direction and financial assistance for the development of Canadian sport and the pursuit of excellence at the national and international level.

BENEFICIARIES

-National organizations serving sport.
-Post-secondary institutions involved in activities such as sport research programs, sport medicine clinics, national sport training centres.
-Canadian athletes ranked 1 to 16 in the world and those who have been identified as having potential to advance to the top 16.

AUTHORITY

Fitness and Amateur Sport Act (1961) provides a general mandate to encourage, promote and develop fitness and amateur sport in Canada.

Following Cabinet approval in 1981 of a major policy paper, emphasis is now on:

-Strengthening the administrative function of the national sports governing bodies to increase their effectiveness.
-Focusing support and effort on the pursuit of excellence in amateur sport.
-Increasing interest and awareness in high profile sport and Canadian amateur sport in general.

In 1983, Cabinet approved a national/federal objective of 9-10th place in nations' standings in the 1988 Winter Olympic Games with a resource allocation of $25 million over five years. In 1985, a target of 6-8th place at the 1988 Summer Olympic Games, with an allocation of $37.2 million over four years, was similarly approved by Cabinet.

RESOURCES ($000's and P-Ys)

Expenditure	82/83 Actual	83/84 Actual	84/85 Actual	85/86 Estimate	86/87 Projected
Salaries	888	1,138	1,314	1,565	1,565
O&M	289	325	402	1,685	1,685
Capital	3	4	34	-	-
Contributions	39,905	42,551	47,870	44,012	45,243
TOTAL	41,085	44,018	49,620	47,262	48,493
Person-years	28	33	32	35	35

* Source: FAS Financial Planning, Management and Services

The dramatic rise in O&M for 1985/86 and 1986/87 is accounted for by a transfer of funds between elements in response to a recommendation by the Auditor General.

$12 million was added, on a permanent basis, to the annual budget of Fitness and Amateur Sport in 1980/81. This amount represents half of the yearly principal of $24 million from the Interprovincial Lottery Corporation as per the 1979 Lottery Agreement.

Proceeds of $100 million phased in over 1985-1988, as per the 1985 Federal/Provincial Lottery Agreement, are going towards the planning and staging of the XV Olympic Winter Games in Calgary but do not form part of the FAS budget.

DESCRIPTION

Fitness and Amateur Sport Branch is a component of Health and Welfare Canada although it reports to Cabinet through the Minister of State for Fitness and Amateur Sport. Sport Canada is one of the two program areas of FAS.

The program's components are:

High Performance Sport/Sport Excellence: This component encompasses those endeavours that have as their objective the attainment of the highest possible level of achievement by Canadian athletes in international sport with particular emphasis on the Olympic Games sports. Sport Canada administers technical programs such as the Athlete Assistance Program, the Sport Science Support Program, the Applied

Sport Research Program and the Hosting Program. It provides technical consultation and financial resources to national sport organizations in such areas as national team programs, national and international competitions, coaching, sport sciences and high performance sport centres.

Domestic Sport Development: This component provides funding and policy direction for the development of technical and competitive programs serving participants below the international high performance level. Major activities of this component include national developmental events such as the Canada Games and respective sport national championships, the developmental programs of the Coaching Association of Canada, and the technical education programs of national sport organizations.

Sport Infrastructure: The activities of this component provide funding and policy direction for the development and maintenance of an effective sport delivery system at the national level. Included in this component are the National Sport and Recreation Centre and those aspects of national sport organizations involving their administrative staff, offices, meetings, planning, etc.

These components are operationally handled by a staff complement of 35 P-Ys.

EVALUATIONS

There has been no formal program evaluation of Sport Canada in the last five years.

OBSERVATIONS

Validity of Program Objectives

The federal government's role in nation-building would appear to have given legitimacy to its support to the amateur sport community's national/international efforts over the past 24 years. The issue now is whether the level of government support can be reduced without adversely affecting that initial investment.

The current legislative mandate is very broad and has allowed expansion in any direction that the Minister of the day believed was necessary. It is difficult to derive jurisdictional authority or specific program objectives from the 1961 FAS Act which does not even define reporting relationships or functional responsibilities. The original involvement of the National Advisory Council on Fitness and Amateur Sport (established by the Act) in policy decision-making and the approval of grants has been eliminated over time due to the creation of the Sport Canada Directorate and its assumption of all program responsibilities.

The three program thrusts of High Performance, Sport Infrastructure and Domestic Sport have been established by policy (1981) and decisions of Cabinet regarding the "BEST EVER" programs for the Winter and Summer Olympics, 1988.

Any decision to continue the "BEST EVER" programs after 1988 will have to be made at the political level. Canada being host for the Calgary Olympics places additional pressure on the system to respond but the "level of service" question needs to be addressed.

In many ways it is not a government-delivered program in that, through a major contributions activity, Sport Canada funds National Sport Governing Bodies (NSGBS) and multi-sport service organizations who, in turn, develop the sports and high performance athletes. Sport Canada is not duplicating other government programs.

The demands on Sport Canada's contributions budget are influenced by a number of external factors over which it has relatively little control, for example:

Number of eligible organizations;

-capacity for accountability by national sports organizations;
-number of sports at major games competitions;
-number of eligible athletes; and
-technical advances in sport development.

Achievement of Objectives

Sport Canada itself does not put a single athlete in the starting blocks; it can only bolster the capacity of national organizations to put their "BEST EVER" athletes in those blocks. Canadian achievements at the Los Angeles Olympics suggest that there has been a demonstrable "pay-off" for the money invested. (Current annual expenditure on the Olympic Summer Sports High Performance programs is approximately $20 million).

The program has had a few side effects in addition to the achievement of specific goals:

- on the positive side, the emphasis on "BEST EVER" programs has generated a cooperative effort between the two senior levels of government and a federal/provincial Blueprint Committee has been established; but
- the injection of more money into the program has had the adverse effect of reducing the pressure felt by NSGBs to seek other sources of funding; and
- as the programs become more technical and sophisticated, the problems inherent in organizations having volunteer boards with professional staff have become more pronounced.

It is difficult to predict whether other ways of achieving the results would be better. No alternatives have been tested. There appears to be no one organization or "stakeholder" who is unequivocally accepted as representing the amateur sport community.

If one accepts that the current programs, services, facilities and performance results are establishing a sound base for progress, it appears to be a cost effective program.

There are both revenue and expenditure "locked in". $12 million has been added to the annual base budget of Sport Canada as a result of the 1979 lottery agreement. Currently, there are "locked in" expenditure commitments for the "BEST EVER" Winter ($25 million over five years) and the "BEST EVER" Summer ($37.2 million over four years) programs.

Impact on Beneficiaries

In one sense the whole amateur sport community is the beneficiary of Sport Canada programs but since just over half of the contributions budget goes to high performance initiatives, the elite athletes have tended to be perceived as the actual beneficiaries. However, the impact of the program should also be judged in terms of the increasing professionalism of the NSGBs, the high technical standards achieved by coaches and officials, and the increased sophistication of the sport science and sport medicine support system.

The NSGBs have inevitably been influenced by government priorities with correspondingly less attention being given to sport development below the high performance level and less attention to marketing their "properties" to lessen their dependence on government financing.

The impact of Sport Canada initiatives on provincial investment lower down the hierarchy of developmental stages for athletes does not appear to be adequately negotiated.

The decision on "How good a ranking is good enough for Canada?" is a political one. Current support for the program entails greater concentration of resources on sports with a demonstrated record of achievement internationally.

Program Efficiency

The program is well known to the major beneficiaries but the results of the federal government's investment are seldom attributed to the Sport Canada program by the general public or, for that matter, by the potential private investment sector. In addition, provincial governments are not always aware of federal program initiatives and want much more consultation.

Since the delivery of program is done primarily through the NSGBs and multi-sport service organizations there is inevitably some resistance to what might be seen as "government interference" when government policy must be adhered to.

There is a need to bolster association management services and in addition, to further develop the federal/provincial "Blueprint" concept.

The features of the program most praised/criticized by staff/clientele are:

- -federal funding priorties skew association priorities;
- -high performance training centres are problematic for some provinces. Federal initiatives have provincial spin-offs that could cost provincial governments money;
- -development of the technical side of sport has been excellent;
- -the management and marketing skills of many associations are very weak;
- -Sport Canada consultants "manage" NSGBs and, in turn, the association professional staff "manage" the volunteer board - too high a level of intervention;
- -overlap with provincial programs in domestic sport development; and
- -disparity among provinces in benefits from Sport Canada program.

The program and the needs of the clients are in a growth mode but are restricted by federal budgetary constraints.

The program does not appear to conflict with other federal programs other than the need to sort out the respective roles of Sport Canada and Fitness Canada in the area of sport. The program is designed to complement provincial support for provincial sport associations although this is not always achieved.

Provincial Comments

There is a need for a national and international presence in sport.

Provincial governments could not assume the responsibility for national or international sport leadership and coordination.

The present Blueprint document is a step in the right direction of delineating federal and provincial responsibilities and overlap in the development of high performance athletes in Canada.

The federal government involvement is viewed as a worthwhile venture and should be continued but with much greater sensitivity to the needs of the provinces and the impact of the program on provincial planning and budgeting.

The location of national training centres has presented a major bone of contention since the majority of provinces feel that there is not sufficient consultation prior to the site decisions being made.

There could be conflict of interest where federal initiatives to encourage corporate investment in national sport programs jeopardize provincial opportunities for corporate dollars.

Impact

For the NSGBs, and the athletes, the program has provided a level of dependable funding based on performance criteria.

By creating and subsidizing the National Sport and Recreation Centre, the program has provided for the physical sharing of facilities and services, and the exchange of ideas, by a wide range of sports.

The competitive potential of athletes is being more fully developed irrespective of geographical location.

The establishment of a national objective of ranking relatively high in world standing has led to a realization of the need for much more sophisticated athlete development models than have existed in the past. Such models, however, demand significant expansion of programs delivered at the provincial level. They also assume a high level of management and technical expertise within the national sport organizations. The implications are that additional resources will be needed; provincial/federal agreement will have to be negotiated; and the sports organizations will have to have the capacity to meet the complex demands of the system.

Federal funding of NSGBs has meant that many of them have not adequately dealt with the issues of raising money by other means. Very few national sport organizations have generated significant income from their membership. In addition, the whole question of members' or participants' contributions towards the costs of development programs for coaches, officials or sports medicine specialists has yet to be addressed substantively. Most NSGBs have no reserve to maintain them through any period of reduced financial contribution.

The traditional role of the volunteer board member is being challenged by the program. As the development of elite athletes becomes more and more complex, boards are facing the potential of radical change in the division of management authority, technical expertise and policy decision-making. NSGBs would be particularly vulnerable at this time to sudden withdrawal of government support.

Reduction in funding would mean the sports which currently have high marketability and/or a large membership would have some difficulties but would survive with more limited capacity. The Olympic sports with low marketability, low membership, or limited capacity to draw support from their provincial affiliates, would face significant problems as would athletes who are not yet top competitors. The advancements in coaching and sport medicine would slow considerably.

Sponsorship of amateur sport does not appear to be a priority for the corporate sector. Corporations have not perceived a need to invest in national sport programs since government is increasing funding in that area. In addition, there are currently major impediments to corporate sponsorship ranging from poor competitive value compared to more conventional advertising and promotional strategies to the limited marketing expertise of NSGBs.

There would appear to be little rationale for Sport Canada's location as a component of Health and Welfare. The program's profile has not been particularly health oriented. Consideration could be given to linking Sport Canada with whatever portfolio best represents the political thrust of the program, e.g., culture, international trade, tourism, etc.

OPTIONS

The study team recommends to the Task Force that the government consider the following:

Phase down the program over a 10-15 year period to give the high performance athlete development system some time to seek and establish sufficient viability, both organizationally and financially, to operate relatively independent of government.

Prior to the onset of the next quadrennial sport cycle, assess the issue of performance ranking being linked to the level of funding authorized for Sport Canada.

- -Continuing current federal government initiatives, and strongly encourage the efforts of NSGBs to build corporate and participant support for the activities of the amateur sport community at the national level;
- -Repealing the Fitness and Amateur Sport Act;
- -Assessing alternative organizational locations for Sport Canada rather than it being a component of Health and Welfare.

INTERNATIONAL SPORTS RELATIONS
EXTERNAL AFFAIRS CANADA

OBJECTIVES

International sports relations are handled by a Sport Desk within the Cultural and Public Information Bureau of External Affairs Canada. The Bureau's objectives are to develop policies and programs to increase awareness of Canada, its identity, culture and capabilities for the purposes of: supporting global foreign policy and trade objectives; fostering markets for the Canadian cultural industry; and providing exposure for Canadian artists (athletes) in key countries.

Specifically, the Sport Desk currently provides:

-advice and briefings to facilitate either overseas operations of Canadian teams or the staging of international sports events in Canada;
-negotiating assistance in concluding sports exchange agreements;
-briefings on Canadian foreign policy when it affects (or may be affected by) the sports community;
-protocol advice.

BENEFICIARIES

Canadian sports governing bodies, through facilitative assistance and occasional grants.

Sport Canada, in the area of sports agreements with other countries and international sports policy.

AUTHORITY

Cultural Policy Division of External Affairs was established in 1974 by a Cabinet decision (#388-74R.D.). The document described the Cultural Division as exporting Canadian culture abroad. Sport was a sub-area within the document; but it was not until 1979 that the Sport Desk was created as a result of the international relations problems raised by the Hockey Canada series.

RESOURCES ($000's) and (P-Ys)

	Actual 82/83	Actual 83/84	Actual 84/85	Main Est. 85/86	Ref. Levels 86/87
Salaries	50,000	53,000	55,200	58,000	58,000
O&M	11,148	70,290**	4,154	10,000	10,000
Capital	--	--	--	--	--
Grants and Contributions	17,057	24,375	*** 109,878	100,000	100,000
TOTAL	78,205	147,665	169,232	168,000	168,000
Person-years	1.3	1.3	1.3	1.3	1.3

* Finance & Management Services Bureau, External Affairs.

** Includes one-time-only item for expenses related to an exhibit at the 1984 Winter Olympics in Yugoslavia.

*** Includes over $100,000 in contributions to send the Canadian Soccer Team on a tour of Africa and to assist the Canadian Badminton Association to attend competitions in S.E. Asia.

DESCRIPTION

The Sport Desk provides political advice and practical assistance to sport groups in their activities abroad. The Sport Desk is an advocate of Canadian sports interests within External Affairs. It coordinates the promotion of Canadian cultural interests abroad through sport, in cooperation with Sport Canada, and assists Sport Canada in developing international sports policy.

Specifically:

-Sport Canada has utilized the services of the Sport Desk at External Affairs in negotiating Sports Exchange Agreements between Canada and U.S.S.R., East Germany, Korea;

-Canadian embassies abroad have been involved in assisting sport groups;

-assistance with the Canadian bid for major games (i.e. 1988 Winter Olympics), has been provided;

- Canadians who are nominees or members of international sport boards or committees are advised on protocol;
- specific sport projects for developing nations are funded; and
- high profile athletes are utilized in trade promotion in other countries (i.e. national ski team in Europe).

EVALUATION

There has not been a formal program evaluation.

OBSERVATIONS

Sport Canada feels that a sport desk within External Affairs is useful but has been under-utilized.

Canada's use of sport as an adjunct to various international needs (i.e. trade shows, tourism, etc.) should be further examined since most current activities appear to be ad hoc and not directly linked to policy areas.

The increasing use of sport for political purposes by other nations emphasizes the need for External Affairs to re-evaluate their commitment to the area.

The Sport Desk should have a more formalized liaison with Sport Canada.

OPTIONS

If the decision is reached that sport can be used as an extension of foreign policy and does provide a positive entry into other areas of international exchange such as trade, tourism, culture, then the Sport Desk program should be given a higher profile.

Maintaining the status quo. This option would suggest that a low priority is placed on this area.

Eliminating the program, recognizing that Sport Canada and the international commitments of the Minister of Fitness and Amateur Sport would still require External Affairs' intervention.

The study team recommends to the Task Force that the government consider directing Sport Canada and External Affairs to complete a thorough evaluation of the role of sport in the area of foreign policy. This study should result in a realistic proposal that would determine the future direction of international sports relations.

TAX MEASURES

Overview

Programs

Medical Expenses
Hospital Purchases
Health Appliances

Observations

Tax measures which provide financial relief are designed to benefit either individuals, corporations or governments by reducing costs.

The rationale for tax measures in the health field is that health products are like food, a necessity of life and therefore should not be taxed (social equity).

In assessing the success of any tax measure, one must consider whether or not the measure meets its objective, operates efficiently and continues to be appropriate.

The Medical Expense Deduction program appears to meet its objective of reducing the cost of medical expenses of those in need, particularly the physically or mentally disabled, the elderly and the bed-ridden.

The Exemption for Health Appliances program provides a federal sales tax exemption to manufacturers of products used by individuals who are disabled or in need. Examples of such products are hearing aids, eye glasses, prostheses, etc.

The Study Team believes that this program is being adequately assessed on a regular basis by the Department of Finance and amended as appropriate to delete products that are no longer medically necessary and to add new products which are medically necessary.

The Hospital Purchases program is designed to reduce the cost of hospital care by providing a tax exemption on all products purchased by hospitals.

In assessing the program, the Study Team found that there are problems with the program regarding the definition of a hospital (when is a health care facility a hospital?) and the maintenance of a current list of hospitals.

Thus the view of the Study Team is that the program is unnecessarily complex in achieving its objectives.

Options

The study team recommends to the Task Force that the government consider:

-maintaining the medical expense deduction.
-maintaining the exemption for health appliances.
-eliminating the tax exemption for health-related establishments, and transfer the monies collected to the provinces as a "block transfer".

MEDICAL EXPENSES
DEPARTMENT OF FINANCE CANADA

OBJECTIVE

To reduce medical expenses to consumers.

BENEFICIARIES

Individuals who incur allowable medical expenses in excess of 3% of net income.

Individuals who are blind or individuals who are confined to bed or a wheelchair by reason of illness, injury or affliction.

AUTHORITY

The Income Tax Act.

RESOURCES

There are no specific resources used to implement this program.

The "forgone revenue" to the federal government as estimated by the Department of Finance is as follows.

	79	80	81	82	83
Forgone Revenue ($ millions)*	32	38	43	57	65

Estimates of forgone revenue for 1984 and beyond are not available.

*Source Account of the Cost of Selective Tax Measures (August 1985) Dept. of Finance.

DESCRIPTION

Individuals make claims for exemptions for medical expenses in excess of 3% of net income through completion of personal income tax forms.

In 1982 (most recent data) 2.2% of the 15 million Canadians who filed returns claimed an exemption under this program.**

The average claim value for 1982 was $1,030.32 (latest data available).**

The average benefit to individual claimants was $170-$200 in 1982.**

EVALUATION

No evaluation was available.

OBSERVATION

The program appears to meet its objective of reducing allowable medical costs (not covered by universal medical/hospital care programs) for individuals.

If the benefits provided under the program were reduced or eliminated, the perception would be:

- that government was taking away a benefit from the blind, the disabled, and the elderly; and
- that provincial governments might have to incur additional costs to compensate for the reductions.

OPTIONS

The study team recommends to the Task Force that the government maintain the status quo, in light of the benefit that this program provides to the physically and mentally disabled and the elderly, and the minimum financial benefit to government of adjusting the benefits provided under the program.

** Source Statistical Services Division,
Revenue Canada Taxation

HOSPITAL PURCHASES
DEPARTMENT OF FINANCE CANADA

OBJECTIVE

To reduce the cost of hospital services.

BENEFICIARIES

Hospitals;

Provincial Governments; and

Canadian Citizens.

AUTHORITY

Excise Tax Act.

RESOURCES

Resources used in Health and Welfare Canada (HWC) to certify "bona fide" hospitals involve approximately 0.3 person-years.

Forgone Revenue

	79	80	81	82	83
Forgone Revenue ($ millions)*	40	55	70	85	95

* Source Account of the Cost of Selective Tax Measures (August 1985) Department of Finance.

DESCRIPTION

Hospitals apply for a Certificate of Exemption from the Department of Health and Welfare Canada. When hospitals purchase goods and services, they use certificates of exemption to exempt items from federal sales tax.

In 1985, 1300 (approx.) hospitals qualified for a Certificate of Exemption under this program.

Auditors from Revenue Canada audit the program during field visits.

EVALUATION

No formal evaluation was available.

OBSERVATIONS

The program was introduced in 1948 at a time when many hospitals were charitable institutions. All hospitals in Canada are now supported by public funds.

The program was introduced during a time when the main vehicle for delivery of institutional health services was hospitals and the "rigid" definition of hospital has not changed although the "form" of delivery of health services to people has changed.

As a result of the rigid definition of hospitals, many provincial governments are experiencing difficulties in having some facilities or services which they regard as a service in place of a hospital receive "Federal Sales Tax Exempt" certificates because they have:

called the facility by a name other than a hospital;

included the hospital as part of a multi-unit management structure; or

reorganized the services provided by the hospital under another form, for example,

"Hospital without walls";
"Home Care"; and
"Community Care Centres".

Staff of HWC have difficulty in determining the status of institutions and in maintaining an up-to-date list.

A duplicate activity of certifying nursing homes occurs in another division of HWC. Approximately 4,400 such facilities qualify for tax rebates.

OPTIONS

-Eliminate existing federal sales tax exemptions for all health related establishments and transfer the funds to provincial governments as "block transfers". (Have the hospitals pay tax and the federal government transfer the value of the tax to the provincial government). This option would reduce the administrative overload involved in assessing whether or not a hospital qualifies for tax exemption status. It would also make government to government transfers simpler.

-Meld the certification of hospitals and nursing homes, etc. under a single procedure for tax exemption purposes. This would have the advantage of unifying policies applying to both sets of institutions and may reduce the administrative overload.

-Expand the scope of FST exempt beneficiaries to include health establishments previously excluded from benefits. This would result in a more equitable treatment of the different types of institutions delivering care and would be more within the spirit of the legislation. The disadvantage of this option is that it would increase level of "forgone revenue".

Status quo.

The study team recommends to the Task Force that the government consider eliminating existing sales tax exemptions for all health related establishments; estimate the total value of the tax and transfer funds to provincial governments as a "block transfer".

HEALTH APPLIANCES
DEPARTMENT OF FINANCE CANADA

OBJECTIVE

To reduce the cost of medical instruments and health appliances to individuals.

BENEFICIARIES

Individuals; and

Provincial governments.

AUTHORITY

Excise Tax Act.

RESOURCES

The latest information "Forgone Revenue" involved in this measure is as follows:

	79	80	81	82	83
Forgone Revenue ($ millions)*	6	8	9	10	11

* Source Account of the Cost of Selective Tax Measures Dept. of Finance Aug. 1985.

DESCRIPTION

This program provides a tax exemption on specific goods and products used for health purposes. The exemption applies at the manufacturer's level.

EVALUATION

No formal evaluation was available.

OBSERVATIONS

The basic rationale behind the exemption is that health goods and products, like food, are considered to be necessities of life and therefore should not be taxed (social equity).

The Department of Finance, on an ongoing basis, has introduced amendments to permit a broader range of products to qualify. There have been occasional deletions of goods and products that are no longer in use (War Veterans' badges 1966).

The Department of Finance continually monitors the program and considers amendments to bring the exemption in line with the philosophy that goods qualifying for the exemption should be medically necessary.

Proposed amendments to the legislation are currently before Parliament to remove the exemption for medical/ and surgical instruments purchased by physicians and dentists.

OPTIONS

Maintain status quo, that is, the number and type of products exempted should be reviewed on a regular basis and products added or deleted as appropriate. This is currently being done by Department of Finance. The Department adds products based on representation from manufacturers and individuals and deletes products based on assessment regarding the validity of such products within the spirit and scope of the Act.

Withdraw the exemption. This would be viewed publicly as requiring the sick and disabled to pay more for products which are medically necessary.

The study team recommends to the Task Force that the government maintain the status quo.

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Guy Desrosiers - Ministère des Loisirs

NEW BRUNSWICK

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J. Carter - Assistant Deputy Minister of Health, Planning & Evaluation
J. Wolstenholme - Assistant Deputy Minister of Health, Community Health
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Suzanne Mason - Director, Sport Branch, Dept. of Youth and Recreation
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NEWFOUNDLAND

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Jim Inder - Assistant Deputy Minister, Parks, Recreation & Wildlife

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